thern Minnesota Medical Association Meeting, Rochester, September 12, 1932
thern Minnesota Medical Association Meeting, Crookston, Sept. 19 and 20, 1932

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CYSTOSCOPIC PROSTATECTOMY

A FURTHER REPORT*

FREDERIC E. B. FOLEY, M.D.
Saint Paul

THE original presentation under this title was made before the Twin City Urologic Society during the winter of 1927[10] and was followed by a preliminary report in the Journal of Urology.[11] It described a new instrument and method for cystoscopic prostatectomy that represented a radical new departure in the treatment of vesical neck obstruction and contained the first reported attempt at transurethral excision of sufficiently extensive portions of the gland to adequately correct obstruction due to large adenomatous hyperplasia.

The punch instruments and methods then in use, because of the small excisions possible with them, had been restricted to bars and contractures except by Caulk,[3] who recommended his own cautery punch in a considerable proportion of obstructions due to ordinary types of benign hypertrophy. The Stern cutting current punch[16] had proved incapable of extensive tissue removal. Faults in its design had made it inferior to its predecessors for small removals and it had been abandoned by its originator.[13]

Unlike punch instruments, the purpose of the new instrument was to relieve all types of vesical neck obstruction, including particularly those caused by large adenomatous hyperplasia. The original instrument and method, presented in 1927, were and still are the only radical departure from the punch and punch principle. They demonstrated that practically any desired extent of the obstructing prostate could be rapidly and accurately excised by an electrode projected far beyond the sheath lumen, thus radically departing from the punch principle and escaping the limitation imposed by excising only tissue that could be impressed into the fenestrum of a punch.

The original procedure was handicapped by rather crude instruments but more so by the very inadequate cutting current generators then available. These generators would not activate in water medium the large surface area of the electrode used. The first attempt to overcome the latter handicap was made by using steep Trendelenburg position to secure passive air distention of the bladder. An immediate fatality due to air embolism of the heart was the result. Inert mineral oil, which is a non-conductor, was then resorted to for bladder distention. This permitted activation of the cutting electrode but the combustion accompanying either cutting or coagulating clouded the oil and its viscosity made rapid flow and clearing of vision impossible, so that the excision once started had to be completed without deliberation or interruption.

In spite of these handicaps a few thoroughly successful cystoscopic prostatectomies were done. These few cases made at once apparent the remarkable possibilities of the instrument and method and prompted the prediction, made at that time, that prostatectomy by ordinary methods would be obsolete within ten years—a prediction that already has gone long strides toward realization.

This was the preface and point of departure to so-called "Transurethral Prostatic Resection." The development of the latter procedure has departed from the ambitious purpose of the original instrument and method as indicated by adoption of the term "Transurethral Prostatic Resection" as contrasted with the more radical "Cystoscopic Prostatectomy."

*Presented before the Minnesota State Medical Association meeting, Saint Paul, Minn., May 25, 1932.

Attempt at clinical use of the original instrument and procedure, beyond the few cases mentioned, did not seem justified until the technical difficulty with which it was handicapped could be without it the generator was produced.[14] That it could have been made available for this purpose was not known until it was put on the market.

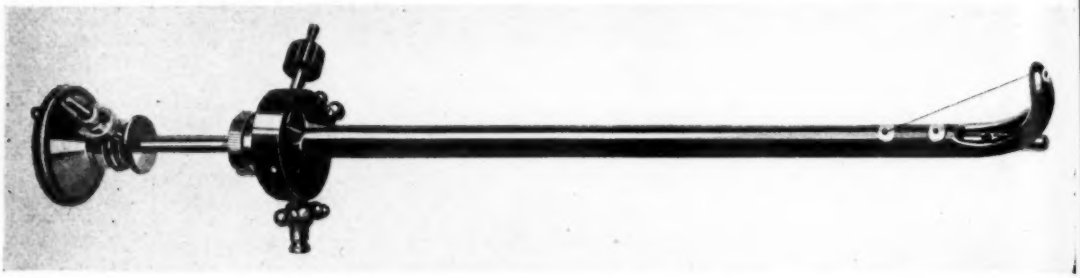

FIG. 1. ORIGINAL FOLEY PROSTATE EXCISOR: ASSEMBLED FOR OPERATION.

The sheath is of vulcanized hard rubber made in the form of a hollow urethral sound of Van Buren curve. Through a slot in the curved end, continued as a fenestrum in the concave wall of the sheath, the cutting current electrode may be viewed with a right angle vision telescope. The latter is shown in the sheath in position for operation. The electrode wire, attached at the tip of the curved end of the instrument enters a tubular conduit in the sheath wall through which it extends back to a spindle or reel at the proximal end of the sheath. By means of this reel the electrode wire may be drawn taut as shown here, in position for operation, or slacked off to lie along the curve of the instrument for introduction as shown in Figure 2. (Journal of Urology.)

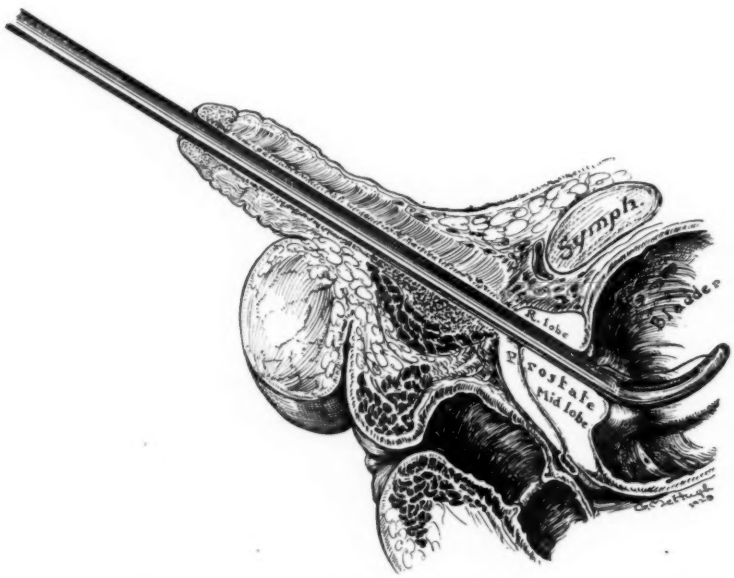

FIG. 2. CYSTOSCOPIC PROSTATECTOMY. ORIGINAL INSTRUMENT AND METHOD. INTRODUCTION OF INSTRUMENT.

The wire electrode is slack, the telescope is drawn back into the sheath of the instrument. The instrument is introduced in the manner of passing a curved urethral sound. (Journal of Urology.)

removed by an adequate cutting current generator. As noted in the preliminary report development of such a generator with early success in routine clinical use of the procedure was in prospect by the promised collaboration of a manufacturer. This collaboration did not materialize but

In the interval since the writer's preliminary report, elaborations of the punch instrument and method have been imposed in the treatment of practically all types of vesical neck obstruction, and with a remarkable degree of success.

The forerunner of all these extensions of the

punch instrument and method was Caulk,[4] whose addition to the punch instrument of galvanic cauterization for control of bleeding permitted the making of "multiple punches" at a single procedure. The significance of Caulk's work does not appear to be properly emphasized in current publications concerning the methods now in vogue.[5]

The outstanding contributor to the recent and more successful extensions of the punch method has been T. M. Davis. He undertook to rehabilitate the abandoned, and originally unsuccessful,

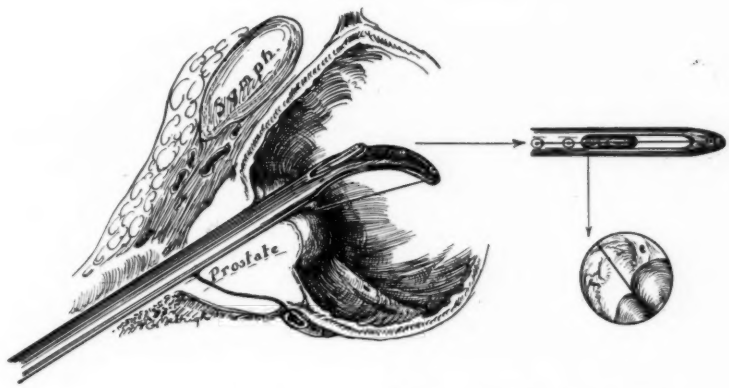

FIG. 3. CYSTOSCOPIC PROSTATECTOMY: ORIGINAL INSTRUMENT AND METHOD. PREPARATION FOR BEGINNING INCISION.

The beak of the instrument has been rotated posteriorly, being directed over the right postero-lateral quadrant. The telescope has ben advanced into the sheath and, as shown in the insert, the lens is placed at the lower margin of the fenestrum. The second insert shows the cystoscopic view obtained: the right ureteral orifice is seen in the background, the wire electrode is entering the cleft between the hypertrophied mid lobe and right lateral lobe. (Journal of Urology.)

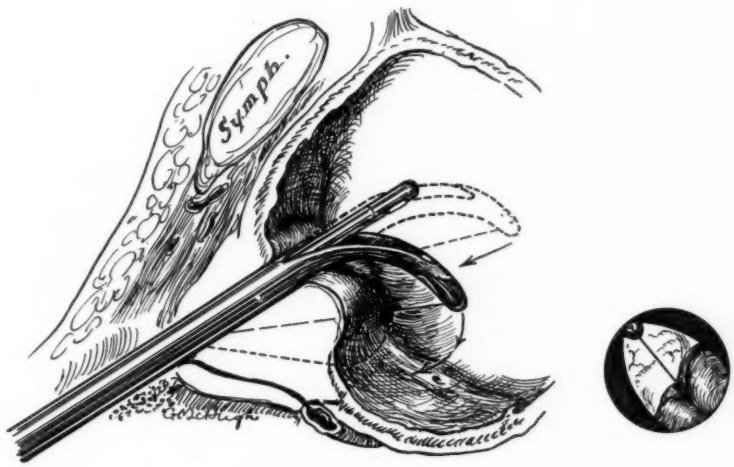

FIG. 4. CYSTOSCOPIC PROSTATECTOMY: ORIGINAL INSTRUMENT AND METHOD. FIRST PART OF INCISION.

The dotted outline indicates the position of the instrument in the urethra as it was at the beginning of the incision, as shown in Figure 3. The whole instrument has been withdrawn to the new position shown here. The high frequency cutting current is supplied to the electrode during this movement and a radially directed incision back into the gland is thus made. At the vesical aspect this incision extends toward the periphery of the gland a considerable distance away from the urethra. In the substance of the gland the bottom of the incision approaches the instrument shaft and terminates in the floor of the urethra. Rotation of the instrument, as indicated by the curved arrows, will continue this incision along the circular dotted line. Note that the telescope has been advanced into the sheath to compensate for the distance the sheath was withdrawn so that the prostate profile, as shown in the insert, is again in view.

Stern punch.[6] This was the first punch instrument to apply the high frequency cutting current to the cutting element. By improvements in design and construction of the instrument and by

FIG. 5. CYSTOSCOPIC PROSTATECTOMY: ORIGINAL INSTRUMENT AND METHOD. ROTATING PART OF INCISION.

The radially directed portion of the incision has been made. The dotted line indicates the path along which the incision will be continued by rotation of the instrument. The incision may be extended farther into the periphery of the gland by withdrawing the instrument and elevating the ocular end. It may be brought closer to the urethra by advancing the instrument into the bladder and depressing the ocular end. (Journal of Urology.)

remarkable persistence, temerity, and endurance, Davis has imposed this instrument in practically all types of vesical neck obstruction.[7] His accomplishment is greatly to be admired; the more so when account is taken of the faults of the original instrument and the handicap of the cutting current generators then available. We are vastly indebted to Davis for so conclusively demonstrating the feasibility of "multiple punches" or "Transurethral Prostatic Resection," as this procedure in its present successful form is now called.

Davis' success in this undertaking was followed by McCarthy,[15] who devised another elaboration of the punch. This very successful instrument, the so-called "Visualized Prostatic Electrotome," makes use of the principles and design originated by Stern, in that the "punch" or cutting element is a wire loop to which a high frequency cutting current is supplied. The loop is moved longitudinally almost entirely within the sheath lumen. Others who have elaborated on the punch instrument and method are Bumpus,[2] Day,[9] and Kerwin.[12] These contributors have devised various forms of the punch with the addition of electro-coagulation of the tissue to be excised preceding the punch cut,

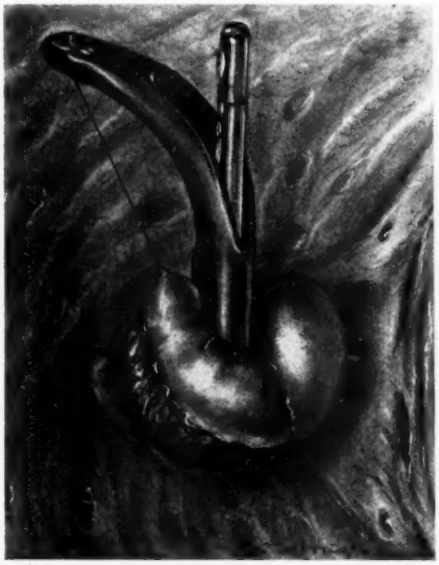

FIG. 6. CYSTOSCOPIC PROSTATECTOMY: ORIGINAL INSTRUMENT AND METHOD. COMPLETION OF INCISION.

Rotation of the beak anteriorly has been completed. The instrument has been advanced back into the bladder, projecting the electrode above the vesical neck and causing it to emerge from the tissue with completion of the incision. (Journal of Urology.)

thus permitting multiple punches at a single procedure.

The present improved cutting current generators, unlike their predecessors, are easily capable of activating in water medium the large surface area electrode of the writer's original instrument described in 1927. The most serious obstacle to routine clinical use of the instrument and method thus was removed. Immediately this was known the effort to make the instrument and method satisfactory for routine clinical use was resumed.

The present further report describes improvements in the design and construction of the original instrument and improvements in operative technic that make "Cystoscopic Prostatectomy" an accomplished fact. Accordingly the title of the preliminary report, "Cystoscopic Prostatectomy," with all its implied ambition, is adhered to as appropriate.

THE ORIGINAL FOLEY PROSTATE EXCISOR

The original instrument and method are illustrated in the drawings and photographs Figure 1 to Figure 7 inclusive. These illustrations are reprinted from the Preliminary Report, The Journal of Urology, volume XXI. The construction of the original instrument and the operative technic are sufficiently described in the captions of these illustrations to require no further comment.

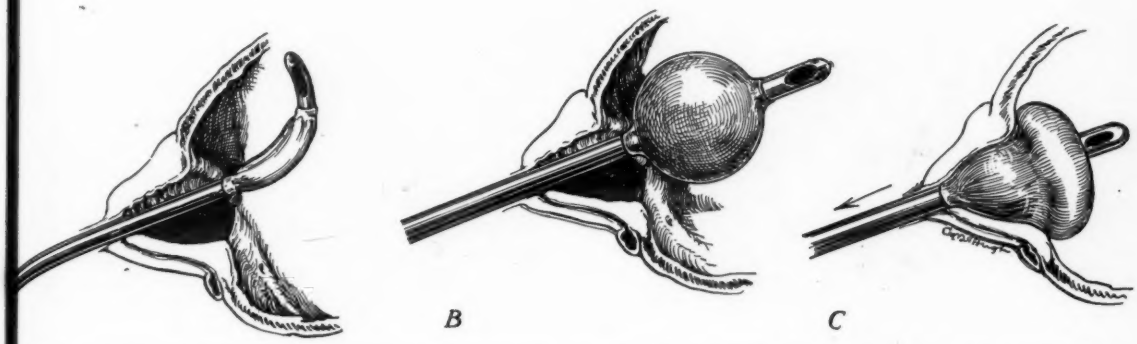

FIG. 7. CYSTOSCOPIC PROSTATECTOMY: ORIGINAL INSTRUMENT AND METHOD. INTRODUCTION OF HEMOSTATIC BAG CATHETER. A, passage on stylet, the catheter being advanced well up into the bladder. B, distention of bag. C, bag drawn down into prostatic fossa. (Journal of Urology.)

The excised piece of tissue was removed from the bladder at a second stage cystoscopic procedure.

As already noted a few successful cystoscopic prostatectomies were done with the original instrument and method. Figure 8 and Figure 9 illustrate respectively the preoperative and postoperative appearance of the vesical neck in one of these cases. This patient completely empties the bladder and is relieved of all urinary symptoms.

Although the technical difficulties already mentioned prevented routine clinical use of the procedure these few cases at once made apparent the remarkable possibilities of the instrument and method. They demonstrated that with this complete departure from the punch principle, consisting essentially of a cutting current electrode supported at both proximal and distal ends and projected far beyond the sheath lumen, it was possible to excise almost any desired extent of the obstructing prostate.

Tests with the new high frequency cutting current generators made it appear that they would eliminate the major technical difficulties of the procedure. This has proved to be the case.

The vastly increased capacity of the new generators makes oil distention of the bladder unnecessary and permits the use of water as cystoscopic medium. Rapid irrigation with water keeps the field clear and the excision may be made with deliberation while bleeding is controlled by supplying a fulgurating or coagulating current to the electrode when needed for this purpose.

Immediately these facts were known there was encouragement and warrant to undertake improvements in design and construction of the instrument and operative technic. This has been done and the procedure has been made satisfactory for regular clinical use.

It will be noted that in the original instrument the electrode was attached to the sheath and was moved entirely by movement of the sheath. Accordingly the position of the telescope within the sheath had to be constantly adjusted to the changing positions of the sheath in order to have the vesical neck properly in view during operation of the electrode. Moreover, with the right angle vision telescope used, the projecting lobes were seen chiefly in profile and if they projected much their peripheral extent was cut from view.

THE IMPROVED FOLEY PROSTATE EXCISOR

In the new instrument the troublesome factors mentioned above have been eliminated by use of

a retrospective telescope and a mechanism for moving the electrode independently of the sheath and telescope. The end of the sheath and telescope remain at a constant level above the vesical neck and the view is directly down on it with the peripheral extent of prostatic enlargement always in the visual field.

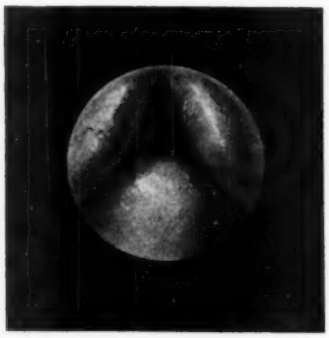

FIG. 8. CYSTOSCOPIC PROSTATECTOMY: ORIGINAL INSTRUMENT AND METHOD. PREOPERATIVE APPEARANCE OF VESICAL NECK AS VIEWED IN PROFILE FROM BELOW WITH BUERGER'S STRAIGHT FORWARD VISION URETHROSCOPE.

There is an elevated, well rounded, projecting mid-lobe enlargement between two moderately enlarged lateral lobes. The junctions of the mid-lobe and lateral lobes are marked by deep clefts in the postero-lateral quadrants.

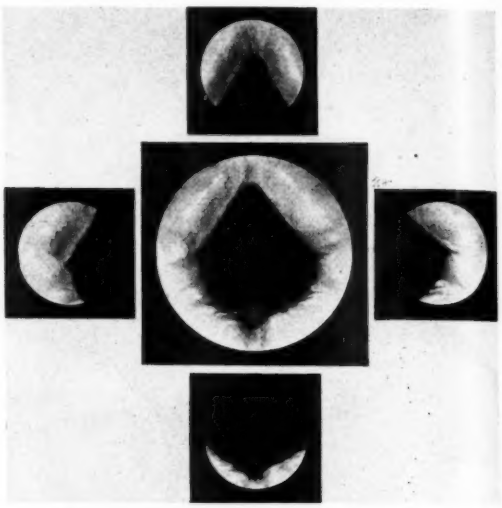

FIG. 9. CYSTOSCOPIC PROSTATECTOMY. ORIGINAL INSTRUMENT AND METHOD. SAME CASE ILLUSTRATED IN FIGURE 8. POST-OPERATIVE APPEARANCE OF VESICAL NECK AS VIEWED IN PROFILE FROM BELOW WITH BUERGER'S STRAIGHT FORWARD VISION URETHROSCOPE.

The vesical neck is too widely open for its whole circumference to come within a single close up field. The small close up profile views of the vesical neck in anterior, posterior and both lateral quadrants were obtained by deflecting the shaft of the instrument in corresponding direction. The large view in the center is a composite of these. The whole mid-lobe and the posterior extensions of both lateral lobes have been removed. The remaining portion of the trigone and the inter-ureteric ridge are dimly visible continuous with the resected vesical neck and urethral floor.

In making the radial parts of the incision the electrode is moved independently of the sheath and telescope, which remain in fixed position while the electrode is seen to incise the gland in an otherwise fixed visual field. This constant position of the sheath is altered only when the whole assembly is rotated in the urethra to make the circular part of the incision. These features have eliminated many troublesome and confusing details in manipulation of the instrument.

The new instrument is simply an extension of the principle described in 1927. Figure 10 is a schematic perspective and sectional view of the new instrument showing details of its design and construction.

The sheath is a straight metal tube of ovoid cross section, size F29. One wall is cut away in the form of a fenestrum continuous with its open end. With this sheath in place in the urethra the working element may be introduced and removed through it at will.

The working element (Fig. 10) is the essential part of the instrument. It is built about a retrospective telescope.* A "deflecting arm," carrying a lamp, is hinged on top of the telescope. A spring mechanism keeps this arm constantly under upward tension. The electrode wire extends from the tip of the arm down to an insulated conduit tube through which it runs back to a reel. The reel serves only to pre-adjust and fix the wire to the length shown in the "position for introduction." It is not used in the actual operative manipulations. The conduit tube is joined to a rack and pinion mechanism by which it may be slid backward or forward on the telescope. The linear movement of the conduit, plus the arcuate movement of the deflecting arm, imparts two components of motion to the cutting element with a resultant movement ideally suited to the intended purpose.

*A new excisor is being constructed in which both retrograde vision of the vesical neck and foroblique vision upward through the urethra are available with the same telescope, which is made a movable part of the working element: retrograde vision being obtained when the telescope with its objective lens is pushed forward close to the mirror and foroblique vision when it is drawn away from the mirror down into the urethra.

An irrigating duct (Fig. 10) alongside the electrode conduit makes a contact union with the left hand petcock of the sheath and, through a slit-like opening near its vesical end, a brisk stream of water is delivered in the visual field within the bladder. A "down draft" return flow occurs through the space along the other side of the telescope and through the right hand petcock.

In the photograph (Fig. 11) the obturator, sheath and working element are shown. The latter is in position for introduction. The rack and pinion mechanism which moves the electrode conduit is all the way forward and permits the deflecting arm to assume a position parallel to the shaft of the instrument, at the same time retracting the electrode close to the instrument.

The photographs in Figure 12 show the working element in place in the sheath. In the upper one the rack and pinion mechanism has been turned back a short distance, making traction on the electrode conduit and wire, thus tipping the light over into position to illuminate the vesical neck. With the instrument in the urethra, in position for operation, the electrode would now be ready to enter the urethra for the beginning of the incision.

In the lower photograph (Fig. 12) the cutting element has completed its excursion, this move-

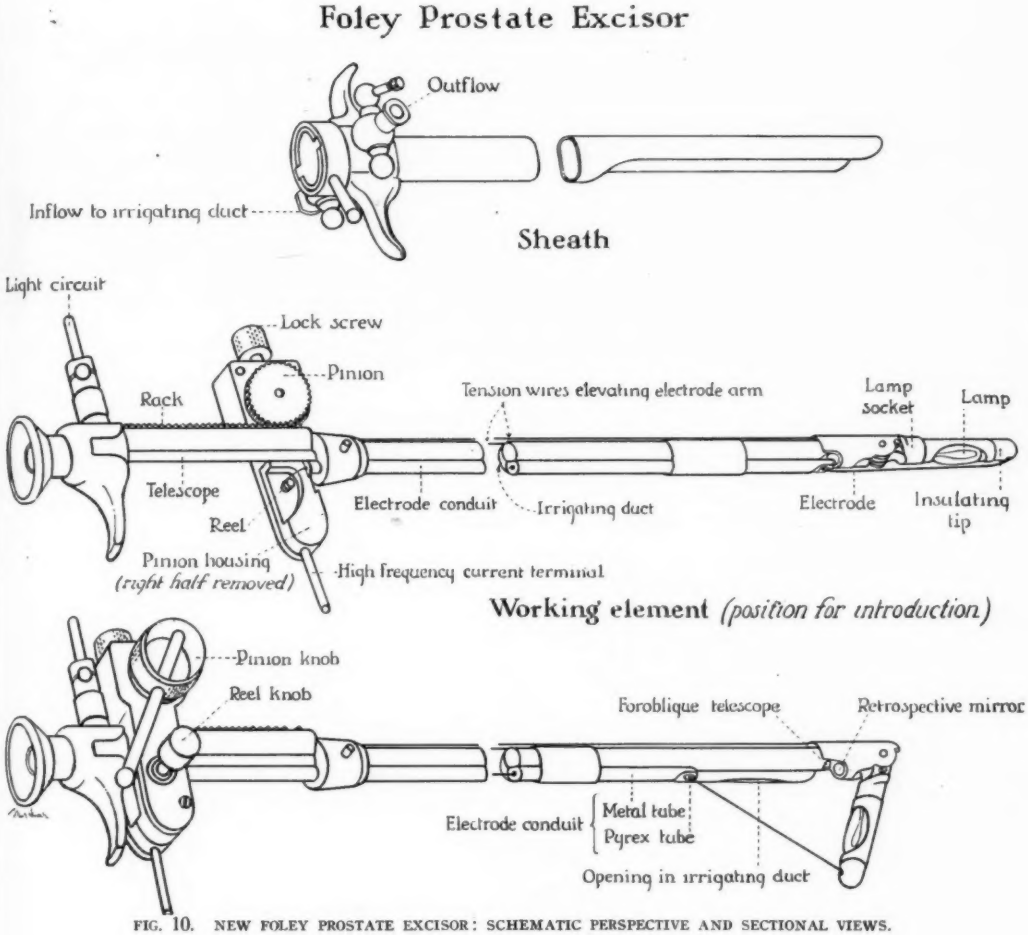

FIG. 10. NEW FOLEY PROSTATE EXCISOR: SCHEMATIC PERSPECTIVE AND SECTIONAL VIEWS.
For description see text, pages 572 and 573.

ment having been effected by operation of the rack and pinion mechanism which is now at the end of its travel.

CYSTO-URETHROSCOPIC MEASUREMENTS

Before undertaking excision of the obstructing portions of the prostate a thorough and detailed survey of the vesical neck and prostatic urethra by means of retrospective, right angle and for-oblique telescopes is essential. Fairly exact measurements are made to determine the extent of peripheral enlargement and how far down in

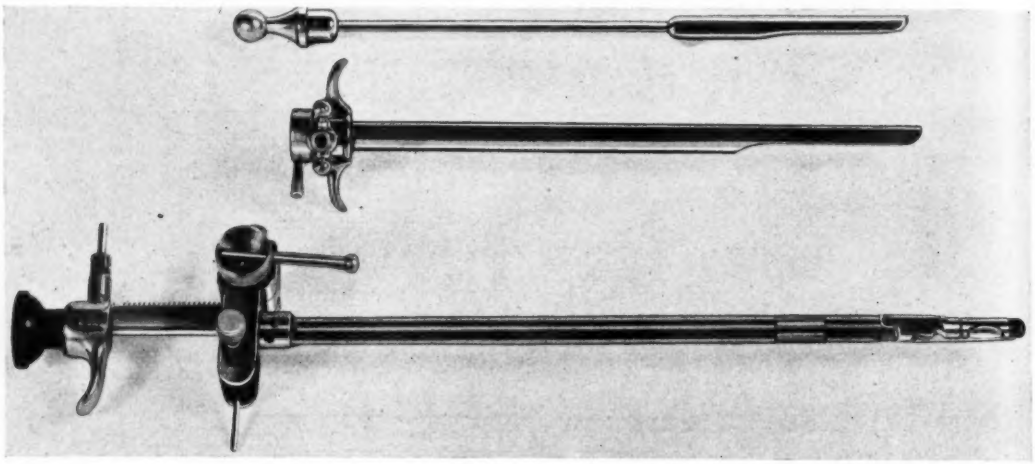

FIG. 11. NEW FOLEY PROSTATE EXCISOR: PHOTOGRAPH OF OBTURATOR, SHEATH AND WORKING ELEMENT.
For description see text, page 573.

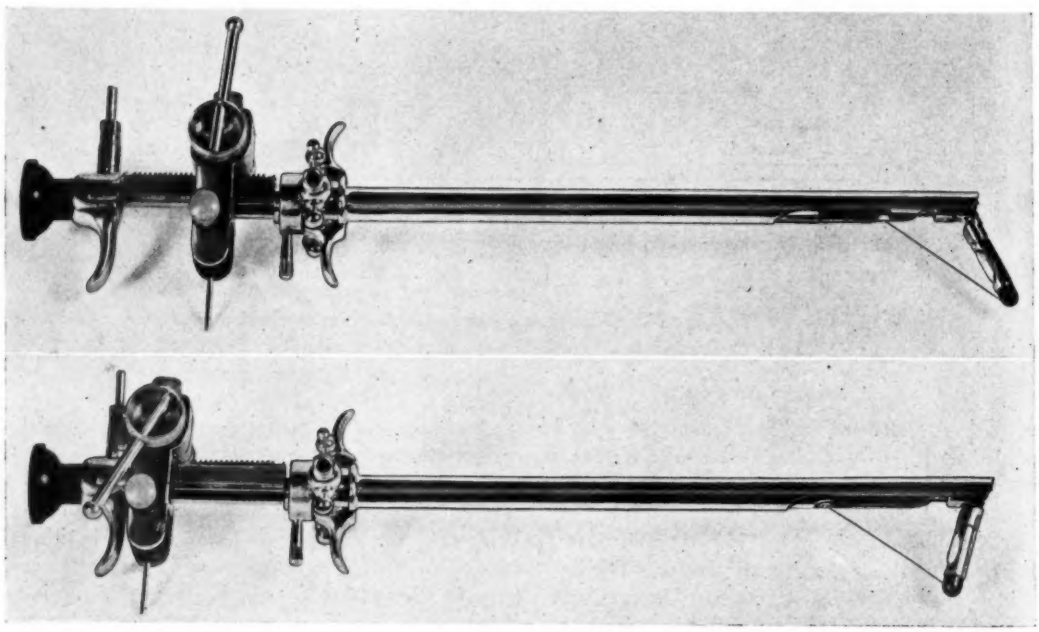

FIG. 12. NEW FOLEY PROSTATE EXCISOR: PHOTOGRAPHS OF THE WORKING ELEMENT AND SHEATH ASSEMBLED FOR OPERATION.
For description see text, pages 573 and 574.

the urethra the encroachment extends. The position of clefts between the lobes and their downward course and extent are carefully noted so that advantage may be taken of them in making the radial portions of the incision. The distance of the verumontanum below the vesical neck is accurately measured as the lower end of the cutting element must not be carried below this point.

From these observations it will be evident just what tissue it is necessary to remove to completely relieve obstruction and the exact method of procedure to be followed in making the excision will be pre-determined.

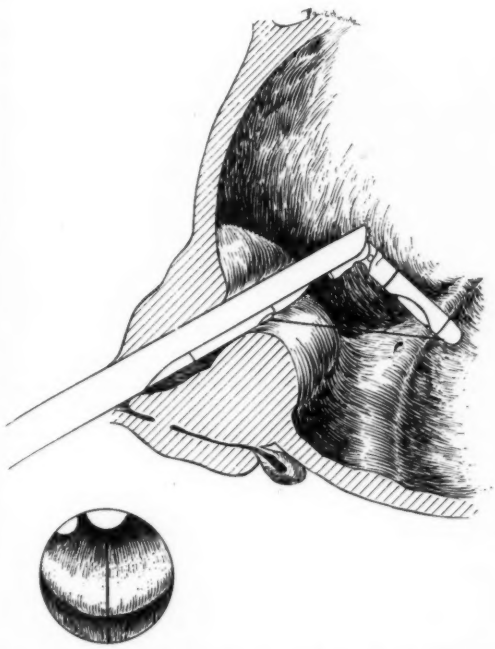

FIG. 13. CYSTOSCOPIC PROSTATECTOMY: NEW INSTRUMENT AND METHOD. PREPARATION FOR BEGINNING INCISION.

The sheath and working element within it are in position in the urethra ready for operation. The electrode conduit has been slid down the telescope carrying the lower end of the cutting element to a point ready to start a radial incision in the prostate. Traction by the electrode wire has tipped the deflecting arm and lamp over to brilliantly illuminate the vesical neck. The cystoscopic view of the vesical neck and projecting prostate and the relation of the electrode to them as seen in the retrograde telescope is shown in the insert. The cystoscopic field of such a telescope gives a mirror image of the object.

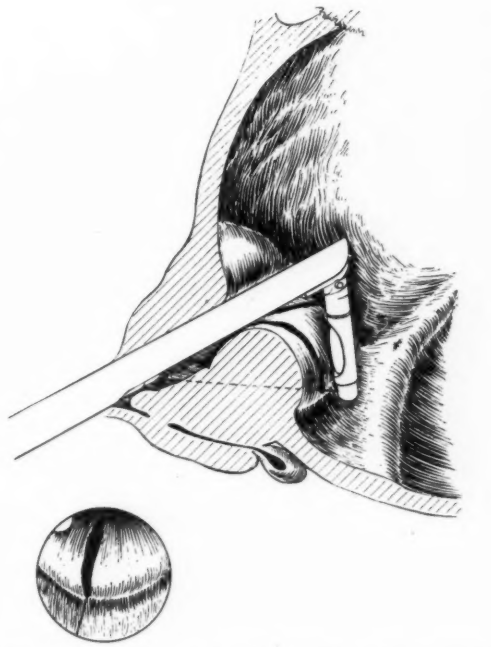

FIG. 14. CYSTOSCOPIC PROSTATECTOMY. NEW INSTRUMENT AND METHOD. RADIAL INCISIONS.

The position of the sheath and working element in the urethra has not been changed and is the same as shown in Figure 13. One radial incision has been made and a second is being completed. In making these incisions the electrode conduit is slid down the telescope from the position shown in Figure 13 to the point of maximal travel shown here. The lower end of the cutting element is thus carried down into the urethra, while its upper end is projected toward the periphery of the gland and its length cuts back into the gland. The cystoscopic view as seen in the retrograde telescope is shown in the insert. Note that the size and position of the projecting lobe appear just as they did in Figure 13; only the position of the electrode has been altered. The radial incision in the gland, extending from the urethra out to the peripheral part of the enlargement, is clearly seen.

OPERATIVE TECHNIC

The method of making the excision is illustrated in the sketches Figures 13, 14 and 15. The radial incisions are first made. In this process bleeding is controlled by alternating the cutting current with periods of coagulation. Particularly in the bottom of each incision should thorough coagulation be employed.

During operation of the electrode continuous "down draft" irrigation is employed; a brisk stream of fluid is supplied from the irrigating duct above the vesical neck with a continuous return flow down the urethra and through the sheath. This carries downward any bleeding from the incision and minimizes interference with vision by blood.

After making the radial incisions, and controlling the bleeding in each one, the sections of gland between them are cut away by rotating the

whole instrument. In making this circular part of the excision the cutting element describes a conoidal surface of rotation.

Note that, except for their rotation in making the circular incision, the sheath and telescope remain in fixed position in relation to the vesical neck during the whole procedure and that the peripheral part of the enlarged gland is always in the visual field without change in magnification as would occur if there were alterations in the level of the objective lens above the vesical neck.

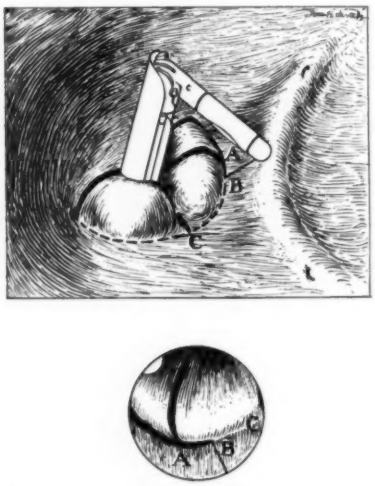

FIG. 15. CYSTOSCOPIC PROSTATECTOMY. NEW INSTRUMENT AND METHOD. ROTATING INCISION.

The radial incisions have been completed. The rotating incision is begun in the radial incision on the right side. It has progressed from this incision past the one next to it so that the block of tissue between the two is now completely severed from attachment. By further rotation of the instrument in the urethra, the incision will be completed as indicated along the dotted line. The cystoscopic view as seen in the retrograde telescope is shown in the insert. The letters serve to identify points in the mirror image.

From the cases thus far operated upon it appears that if bleeding in the radial incisions has been adequately controlled, only slight bleeding will occur from the circular or rotating incision.

The excised pieces of tissue are removed from the bladder with an accessory instrument referred to below.

Upon completion of the procedure an F26 catheter is fixed in the urethra.

ACCESSORY INSTRUMENTS

Additional means for control of bleeding is provided by another element consisting of a for-oblique telescope, fulgurating electrode and irrigating duct. This element is interchangeable with the working element in the sheath of the instrument. By removing the working element from the sheath it may be inserted for use at any time. Without the fulgurating tip it may be used for inspection within the urethra. A right angle vision telescope with light is also provided for use in the sheath for check-up examination and orientation whenever needed.

Thus far the excised pieces of tissue have been removed with a Young cystoscopic rongeur. This instrument is not operated in a sheath and accordingly passage and removal of it is required for each piece of tissue taken out of the bladder. The tissue, grasped in the jaws, is brought through the urethra without the protection of a sheath. In the case of large pieces (Fig. 16) this may be very undesirable.

For removing the excised pieces, Mr. Reinhold Wappler, The American Cystoscope Makers, Inc., is making a suitable grasping forceps to be operated in a sheath of the same calibre as that of the operating instrument.

COMMENT

In Figure 16 five pieces of gland from five different cases are shown. The one at the left was removed with the Stern instrument. The average weight of such pieces is about one-fourth of a gram. The next piece was removed with the McCarthy instrument. The average weight of such pieces is about one-third of a gram. The three large pieces were removed with the Foley excisor. The one at the right weighed six grams, which is the equivalent of 24 Stern pieces or 18 McCarthy pieces. Fortunately the urethra was unusually roomy and the tissue sufficiently soft and pliable to permit removal of this piece with the Young rongeur. Pieces of such dimensions should be broken up before removal.

The above comparison makes obvious only one of the advantages of the new instrument and method over the cutting current punches now in vogue. It may be summed up in the adage: *The usual method of cutting off a dog's tail has much to recommend it.*

In dealing with bars, contractures and small hypertrophies, not requiring extensive tissue removal, the new punch type instruments, particularly the McCarthy, are excellent though they have no advantage over the writer's new excisor even in such cases. They have, however, greatly

extended the field and improved the technical facilities of the original punch principle.

In cases of extensive enlargement the punch type instrument is at a considerable disadvantage.

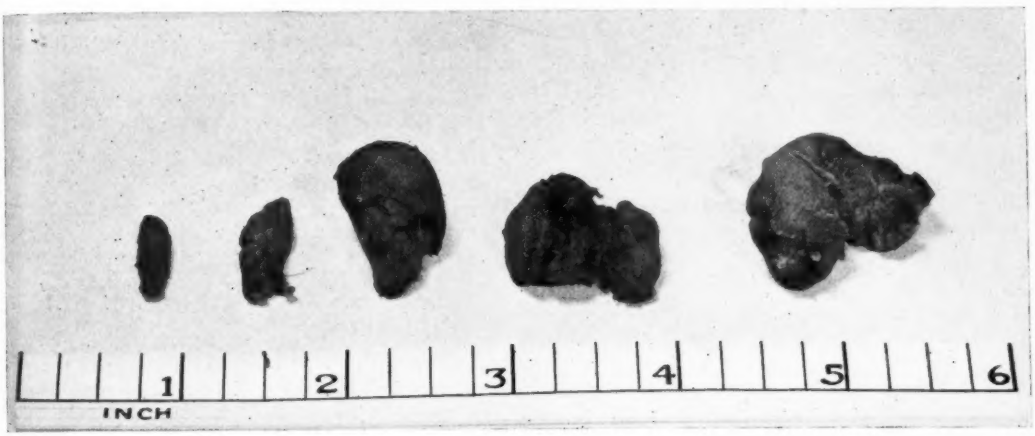

FIG. 16. PIECES OF PROSTATE FROM FIVE DIFFERENT CASES.

The small piece at the left was removed with the Stern instrument. The one next to it was removed with the McCarthy instrument. The three large pieces were removed with the Foley Excisor. The one at the extreme right represented almost the whole mid-lobe and weighed 6 gms. See text, page 576.

In the first place the projecting lobes at the vesical neck are seen only from the urethral side and appear in profile, while the extent of peripheral enlargement is only discovered after the tissue on the urethral side has been whittled away. If much tissue is to be removed this whittling process is time consuming and troublesome. With every punch cut, bleeding may be started anew and repeated applications of the coagulating current are thus required.

In cases in which the new instrument and method have been employed the procedure has gone with remarkable smoothness, rapidity, and accuracy of visual control. In no case has control of bleeding presented any difficulty and use of the hemostatic bag catheter, described with the original instrument,[11] has not been required. With few exceptions the convalescences have been uneventful and the functional results, thus far, have been excellent—large forceful streams, complete emptying of the bladder and relief of symptoms. A subsequent report will set forth full details of clinical experience including eventual end-results.

While the present "Further Report" is concerned entirely with the subjects of instrument design, construction and operative technic, and is not intended in any way as a report of clinical experience, it may be said at once that these methods of dealing with prostatic obstruction are here to stay and that it is only a question of determining from large clinical experience what few cases, if any, may require major surgery. The writer's experience, comprising only 32 cases, is entirely too limited for the drawing of conclusions. It is significant, however, that in the period covered by this experience, only two prostatectomies by ordinary methods of enucleation have been done, while the cases treated by transurethral methods have given immediate functional results as good, if not better than those obtained by enucleation. It is evident, therefore, that over 90 per cent of the cases of bladder neck obstruction encountered during this short period have been found satisfactorily amenable to minor transurethral surgery and presented no warrant for the hardship of a major operation. This is in essential accord with the experience of Davis,[7] and that of Alcock.[1]

The experience of Davis,[8] who has used the Stern cutting current punch continuously for four years, disposes of the misgiving that recurrence of obstruction is to be expected (at least within such a period) more frequently than with the ordinary type of major surgical removal.

The initial resistance on the part of some urol-

ogists, which at first found almost vehement expression, is on the wane and already many of them regard the procedure with favor, clinging only to the recommendation that it be not imposed in unsuitable cases. The new instrument and method described here remove many of the difficulties presented by the present punch instruments, in dealing with extensive enlargements requiring large tissue removals, and accordingly there remains only, a very small number of cases in which the method would be *imposed.*

The procedure makes demands on the best abilities of the skilled and experienced transurethral operator. In such hands it carries no unusual hazard and excellent results are regularly obtained. It is scarcely to be expected that the demands of the technic will be met by the casual cystoscopist or that, under such circumstances, the procedure will not be hazardous or that the results will be those attainable. Adverse criticism from such experience may be looked for but to the fair judge it can mean nothing. The large experience already had is ample proof that in competent hands these methods are eminently successful. The eventual and permanent appraisal of "The New Surgery of Prostatic Obstruction" can only be concerned with the results obtained in such hands. Accordingly upon the thoughtful practitioners who will make the final appraisal of these methods, it is incumbent to consider not only the content of reports but also the talents of the reporters.

Critics of this new enterprise express themselves as well satisfied with major prostatectomy, the hardships and economic loss of which are to be lightly passed over. This happy view is not shared by all competent and experienced urologic surgeons nor by many patients. Such critics must not be aware of their failures with prostate removal by major operation, for personal clinical contact with some of their cases of poor results has contributed somewhat to an inability to share their happy view of the open operation. Any surgeon of experience knows that major prostatectomy imposes suffering, anxiety, large risk to life, long convalescence, economic loss and financial hardship. Experience to date has satisfied those familiar with the new procedure that any competent cystoscopist who is willing to devote his talents and skill to these transurethral operations can thus adequately relieve a vast majority of prostatic obstructions and for him it is justified to impose major surgical removal in only a very limited and rapidly diminishing number of cases.

SUMMARY AND CONCLUSIONS

1. The ambitious purpose initiated by the writer in 1927 to make prostatectomy a relatively minor transurethral procedure has been brought to successful conclusion.

2. So-called transurethral prostatic resection with the punch instruments now in vogue has already proved that such methods should supplant major surgery in a large percentage of cases.

3. A new instrument and method representing a radical new departure from the punch principle is described: an electrode projected far beyond the sheath lumen, and operated under accurate visual control, permits rapid excision of practically any desired extent of the obstructing gland amounting in fact to "cystoscopic prostatectomy."

4. In the hands of the competent cystoscopist a vast majority of prostatic obstructions can be relieved by "cystoscopic prostatectomy" or by "transurethral prostatic resection" and, for him, removal of the gland by major operation is justified in only a very limited number of cases.

5. The time has come to speak in terms of what small percentage of cases will require major surgery rather than the percentage of cases in which transurethral methods can be imposed.

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A COMPARISON OF LESIONS ASSOCIATED WITH DUODENAL ULCER IN GERMANY AND IN THE UNITED STATES*

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and
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BEFORE contrasting the lesions associated with duodenal ulcer in Germany and in the United States, it might be well to consider briefly the present-day treatment of duodenal ulcer in the United States.

There seems to be little doubt that, in the majority of cases, acute nonperforating duodenal ulcer with mild symptoms of short duration can be adequately controlled by proper maintenance of the relationship of diet, habits and the neutralization of gastric acidity. The patient with chronic duodenal ulcer, however, who has failed to respond to these methods of treatment and whose symptoms interfere with the proper carrying out of work or other activities, is best treated surgically. This, of course, includes patients with duodenal ulcers who have such complications as obstruction, hemorrhage and evidences of perforation. For chronic ulcers, therefore, the earlier a proper surgical procedure is carried out in indicated cases, the sooner patients can return to their usual occupations.

Many observers appear to believe that too much credit has been given to the so-called medical treatment of chronic duodenal ulcer. This has not been entirely the result of the enthusiasm of the internist and the gastro-enterologist. The tendency of surgeons in Germany to favor partial gastrectomy and its adoption by a few surgeons in this country as a routine procedure for all cases of duodenal ulcer without recognition of the variable pathologic changes, has obscured the fact that excellent results are obtained in 90 per cent of cases in this country in which conservative surgical procedures such as gastro-enterostomy or pyloroplasty with excision of the ulcer, are instituted. This is particularly true when the operative risk or mortality of gastro-enterostomy or pyloroplasty with excisions of ulcers is approximately 1 per cent. In considering the place of gastro-enterostomy in the treatment of duodenal ulcer, the figures obtained by the British Medical Association in an investigation in 2,609 cases, showed that the results of gastro-enterostomy were satisfactory in 89.5 per cent of cases. General improvement in health and well-being occurred in all but a few cases and secondary gastrojejunal ulcer occurred in only 2.8 per cent. Since these results are practically identical with those reported by Moynihan and by Walton in England, by Gosset in Paris, and by Balfour in the United States, it would seem that they can be accepted as standards of operative results.

Judd and Hazeltine reported satisfactory results in 90 per cent of cases in which excision of the ulcer with pyloroplasty was performed at The Mayo Clinic. They also stated that the risk of the operative procedure was less than 1 per cent, and that the operation is applicable in 50 per cent of cases of duodenal ulcer. Similar good

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results were reported by Finney and Hanrahan, in 251 cases in which pyloroplasty with excision of the ulcer was carried out. Satisfactory results were obtained in 86 per cent of the cases.

Fig. 1. Resected portion of stomach and duodenum showing ulcerative and hemorrhagic gastritis, associated with multiple duodenal ulcers (Schmieden Clinic).

Fig. 2. Resected portion of stomach and duodenum showing hypertrophic gastritis with perforating duodenal ulcer (Schmieden Clinic).

On what basis, therefore, has gastric resection been accepted as a preferable procedure for the treatment of duodenal ulcer by surgeons in Germany? The answer is summarized in Konjetzney's report of ulcerative and hemorrhagic gastritis involving the antrum of the stomach, associated with duodenal ulcers in practically all cases in Germany, and by Sebening's observations that the ulcers seen in these cases in which operation is performed are more extensive, and are more frequently associated with chronic gastric ulcer (one to four in contrast with one to ten in The Mayo Clinic) and the higher incidence of recurring ulceration after gastro-enterostomy or pyloroplasty in Germany. Konjetzney believes that these inflammatory changes in the mucosa of the stomach are not secondary conditions of ulceration surrounding the ulcer, but are primary or parallel to the initial stage of duodenal ulceration. Substantiating his opinion that gastritis is a predisposing factor in the formation of ulcer he stated that in Germany this type of gastritis (with clinical symptoms of ulcer) occurs in cases without duodenal ulcer and that it involves the entire pyloric end of the stomach irrespective of the site of the ulcer.

The associated gastritis is, for the most part, of the ulcerative type and may or may not be associated with additional hemorrhagic areas of subacute and chronic inflammation (Fig. 1). The ulcers are more marked in the region of the lesser curvature, varying in number from a few to twenty or thirty and penetrating to the muscularis mucosa. Besides the ulcerative type of lesion, there is a hemorrhagic type accompanied in the early stages by hypertrophy of the mucous membrane (Fig. 2). Later this type appears to pass into the atrophic stage of gastritis. It is not uncommon to find the fibrinous exudate in the form of a white membrane spreading diffusely over the area of ulceration. In practically all cases, the areas of ulcerative gastritis are confined to the antrum or lower third of the stomach, whereas the area of hemorrhagic gastritis, although confined to the antrum, occasionally extends to the middle and upper third of the stomach. Microscopically, the lesions are characterized by typical areas of ulceration of the mucous membrane and covered in some cases by

an exudate composed of fibrin and leukocytes. Marked leukocytic infiltration of all layers of the resected antrum of the stomach is noted. The duodenal ulcers themselves, for the most part, tend to be multiple and seem larger and more of the penetrating type than those generally observed in this country.

In April and May of 1931, Walters and Snell in visiting German surgical clinics, had an opportunity to study portions of the stomach and duodenum resected for duodenal ulceration and also specimens which had been removed previously. The constant occurrence of associated gastric lesions in clinics in Germany as described by Konjetzney was demonstrated. In discussing with surgeons in Germany these associated infectious lesions of the antrum of the stomach and mentioning their infrequency in association with duodenal ulcer as seen during operations at The Mayo Clinic, the question was raised as to whether at the time of operation for duodenal ulcer in which pyloroplasty or gastro-enterostomy was performed, one can inspect the antrum of the stomach sufficiently to determine with any degree of certainty that such associated gastric lesions were not present. We now have proof that similar types of gastritis are rarely present in cases in which operation is performed at the clinic. Furthermore, with these gastric lesions absent in a majority of our cases of duodenal ulcer, it would seem that not only pathologically but biologically, the lesions differ in the contrasting groups, hence surgical procedures directed toward cure in one group of cases may not be indicated in the other. Further differences between the types of peptic ulcers seen in The Mayo Clinic in comparison with those seen in clinics in Germany are evidenced by the fact that in the former the relation of gastric ulcers to duodenal ulcers is about one to ten. In Schmieden's clinic in Frankfurt, this relationship is one to four and in the reports of the surgeons in some of the other clinics in Germany, even one to one.

There is the possibility that this diffuse inflammation of the stomach, for the most part ulcerative, with its higher incidence among patients in Germany may explain the higher incidence of recurrence of ulceration following gastro-enterostomy or pyloroplasty in contrast to that found in this country. With subacute, hemorrhagic and ulcerative gastritis in the lower portion of the stomach, the stoma made at gastro-enterostomy or pyloroplasty is placed in the area of gastritis. Hence it would seem possible that the few cases in which ulcer recurs after gastro-enterostomy or pyloroplasty may be of this type, and that recurrence can be prevented if the few cases in which gastritis exists with duodenal ulceration are recognized and the ulcerating areas removed. Resection of the ulcerated portion of the stomach and duodenum has been carried out at The Mayo Clinic for many years when gastric and duodenal ulcers were associated.

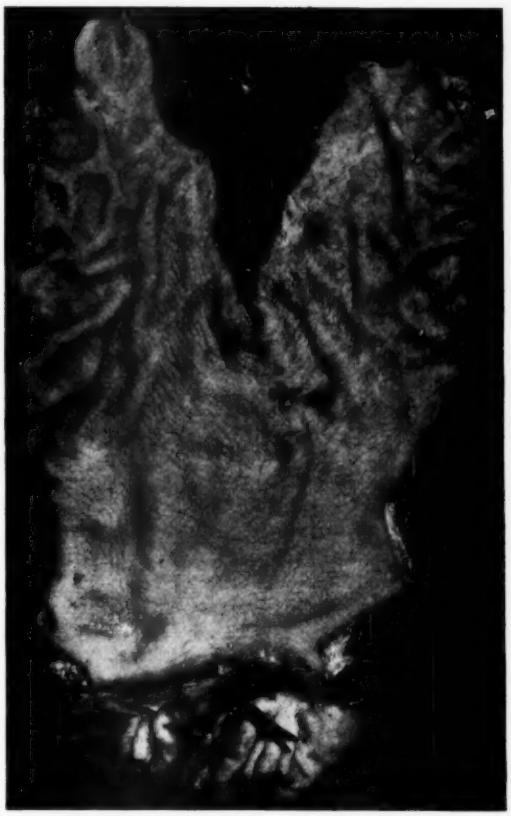

Fig. 3. Resected portion of stomach and duodenum showing perforating duodenal ulcer, penetrating contact duodenal ulcer; no gastritis (The Mayo Clinic).

Following the visit to Germany, the question of gastritis and duodenal ulcer was discussed with Balfour, MacCarty and Robertson, and it was decided that a detailed study would be made of the stomach and duodenum in cases of duodenal ulcer in which operation was performed. One of us (Walters) has, therefore, in the last

ten months, performed gastric resections of the Billroth I and posterior Polya types for duodenal ulcer in cases in which the risk of the operation would not seem to mitigate against the

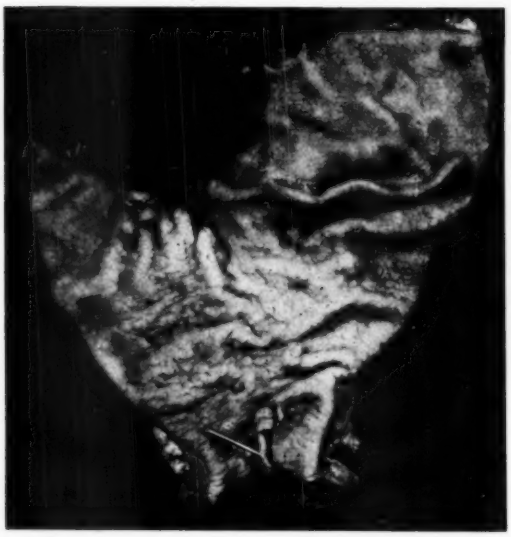

Fig. 4. Resected portion of stomach and duodenum showing duodenal ulcer; no gastritis (The Mayo Clinic).

recovery of the patients. Lesions chosen for resection were those of duodenal ulceration of the perforating, hemorrhagic and obstructing types (Figs. 3 and 4). In only two of the specimens was gastritis associated; in one of them, the presence of the gastric ulcerations had been demonstrated in roentgenograms prior to operation (Fig. 5); in the other, the presence of the ulcerative gastritis was evidenced by the unusual thickening and congestion of the lower portion of the stomach to palpation and inspection. This patient had had two severe hemorrhages from the ulcer or ulcers. In both cases, necessity for gastric and duodenal resection was apparent because of the multiplicity of the lesions. With the exception of these two cases, there was no evidence of either the ulcerative or hemorrhagic type of gastritis associated with duodenal ulcer.

In two other cases in which resections of the stomach were done for gastrojejunal ulcer, gastritis was evidenced, in one case by a superficial gastric ulcer, and in the other, in which a recurring, obstructing duodenal ulcer had developed after pyloroplasty, ulcerative gastritis was demonstrated in the resected portion of the stomach.

That essential differences in other types of lesions exist in different countries, or indeed in different parts of the same country, is apparent when one studies the distribution of cases of

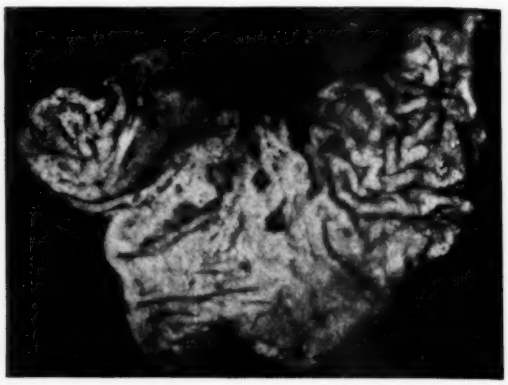

Fig. 5. Resected portion of stomach and duodenum showing ulcerative gastritis (The Mayo Clinic).

enlargement of the thyroid gland, and recalls the so-called goiter belts in this country, in which the thyroid gland is excessively enlarged, and the variable geographic incidence of associated hyperthyroidism. In Germany, in the mountainous regions near the source of the Rhine, there are said to be only a few cases of exophthalmic goiter, which is in direct contrast to the proportion of goiter existing in the northern provinces of Germany along the same river. Certain surgeons have noticed that there is a marked difference in the types of duodenal ulcer and the degree of associated gastritis in two cities along the Rhine only sixty miles apart. Further evidence of the geographic variability, possibly associated with changes of metabolism, is the increasing development of calculi in the urinary tract which has occurred in almost geometric progression in some parts of Germany in the last ten years. For the most part, the urinary calculi exist without urinary infection, and the similarity of their percentage of development in relation to that of exophthalmic goiter in the various provinces around the Rhine, as noted by Braun, is striking in that where exophthalmic goiter has been infrequent in appearance, so have urinary calculi been infrequent. This geographic variability is more striking when one considers that in both exophthalmic goiter and duodenal ulcer the lesions are accompanied by oversecretion. Further, during this

same period of ten years, there has been an alarming increase in the proportion of fatal postoperative pulmonary emboli in Germany; this increase has not occurred in some of the surgical clinics in Paris with which I am acquainted, nor has it occurred in the clinics in the United States. It may be that the incidence of postoperative pulmonary embolism has a distinct relationship to metabolism, and the recent work of Bancroft and Stanley-Brown would seem to indicate that a diet high in protein tends to increase the clotting time of the blood. These facts, I believe, will add additional weight to the argument that the lesions associated with duodenal ulcer vary pathologically and probably biologically in different localities and among different people, and that surgical procedures directed toward the treatment of one group of cases may not be indicated in the other.

It should be remembered, furthermore, that the average risk of partial gastrectomy, including partial duodenectomy, varies from 5 to 10 per cent in the hands of skillful and experienced surgeons, and this risk increases proportionately from 13 to 15 per cent, as reported from one of the European clinics, depending on the size, fixation and degree of penetration and the extent of the resection of the duodenum necessary to remove it. On the other hand, the infrequency with which such accompanying inflammations in the stomach have been present in cases in which operation had been performed at The Mayo Clinic had led to the belief that in most cases in which operation is performed, excellent results can be expected by gastro-enterostomy or pyloroplasty with excision of the ulcers. These procedures can be carried out with a risk of 1 per cent or less. Should associated inflammatory changes and ulcerations exist in the stomach in connection with duodenal ulcer, it would seem to indicate a place for removal of these ulcerating areas; this applies particularly to the bleeding type of ulcer.

SUMMARY

Portions of the stomach and duodenum, resected for duodenal ulceration, in some of the surgical clinics in Germany, are contrasted with specimens removed at The Mayo Clinic. In the lesions removed in Germany, marked gastritis was found. These lesions are for the most part ulcerative, are confined to the antrum of the stomach, and may or may not be associated with hemorrhagic gastritis and hypertrophy or atrophy of the mucous membrance. Konjetzney found gastritis to be an accompaniment of duodenal ulcer in practically all such resected specimens. In a study of the antrum of the stomach in cases of duodenal ulcer in which operation was performed at The Mayo Clinic the very rare association of gastritis was noted, evidence being presented by specimens removed at the time of operation.

It appears, therefore, that the lesions in the two countries differ, not only pathologically, but biologically, hence the surgical procedures directed toward the treatment of one group of cases may not be indicated in the other. The probabilities are that the gastritis associated with duodenal ulcer in Germany accounts for the higher incidence of recurrence of ulceration following the conservative operations of gastro-enterostomy and pyloroplasty, in contrast to the low incidence of recurrence in this country. It would seem possible that the explanation for the development of recurring ulcer in the few cases (approximately 2.5 per cent) after gastro-enterostomy and pyloroplasty, might be the association of inflammatory changes in the stomach. This small incidence of recurrence might be prevented if such cases were distinguished from those in which ulcerative gastritis is not associated. In two of our cases, associated ulcerating lesions of the stomach were known to exist. In one case they were demonstrated roentgenologically, and in the other there was palpable evidence of thickening and congestion in the lower end of the stomach. In substantiating the idea that variability in pathologic lesions exists in different geographic regions, attention is directed to the variability in the incidence of toxic goiter, urinary calculi and postoperative pulmonary emboli in different countries.

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IMPORTANT POINTS IN THE SURGERY OF THE DISEASED THYROID*

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GOITER operations are based on one of two principles: either the surgeon follows no special plan, excising the goiter as he would any other tumor and ligating the blood vessels as they bleed, or he follows methodically a definite procedure based on the anatomy of the thyroid and its related structures. With either method, the immediate result of the operation appears to be the same. The operative mortality in thyroid surgery, the main factors in which are the condition of the heart and kidneys, or some constitutional disorder, is scarcely one per cent.

However, something beyond the operative mortality enters into the question, namely, a cosmetic and functional result and the avoidance of complications. The most frequent technical complications in the surgical management of goiter are, injury to the laryngeal nerves, injury to the parathyroid bodies and hemorrhage.

It will be the purpose of this paper to show that these accidents can best be avoided by a careful technic, based on detailed attention to the anatomy involved.

*Presented at the annual meeting of the Minnesota State Medical Association, Saint Paul, May 25, 1932.

SURGICAL ANATOMY OF THE THYROID

The surgical anatomy of the thyroid is concerned mainly with the blood supply, because in the surgical treatment of the diseased thyroid gland, injury to the laryngeal nerves and parathyroids occurs probably most often in the attempt to apply ligatures to the thyroid arteries and in the control of hemorrhage within the capsule. Therefore, a brief review of the anatomy involved in thyroidectomy, will be helpful. The sketches shown were made from our dissections.

Figure 1 shows the extralaryngeal relations of the superior pole of the thyroid gland. Insert C shows the close proximity of the superior thyroid artery to the superior laryngeal nerve and demonstrates the possibility of injury to this nerve in the attempt to ligate the superior thyroid artery in the course of the operation.

Figure 2 shows a dissection of the left side of the neck and demonstrates the anatomical relations of the left recurrent laryngeal nerve and the inferior thyroid artery. Injury to this nerve might be sustained during the mere delivery of a substernal enlargement of the left lobe of the thyroid, or an intrathoracic goiter, because the left recurrent nerve curves over the arch of the aorta. From this dissection, as well as that in Figure 3, it is evident that the nerve might also be injured in the attempt to grasp bleeding branches of the inferior thyroid artery. The nerve passes between the branches of the artery within the capsule of the gland.

Figure 4 demonstrates the course of the inferior thyroid arteries and their relation to the recurrent laryngeal nerves, as well as to the parathyroid bodies. As indicated in the drawing, and proved through investigation of Enderlin and Hotz, Halsted, Mastin, Wangensteen and others, the parathyroids receive their blood supply from a fine branch of the inferior thyroid artery, or by a branch artery, connecting the inferior with the superior thyroid artery. Clinically, therefore, if ligation of the inferior thyroid artery is contemplated, the ligature should be applied as far away as possible from the terminal branches to permit good collateral circulation to these structures. With these anatomical facts in mind, we will proceed to the actual operation.

THE OPERATION

Only the points relevant to the subject matter

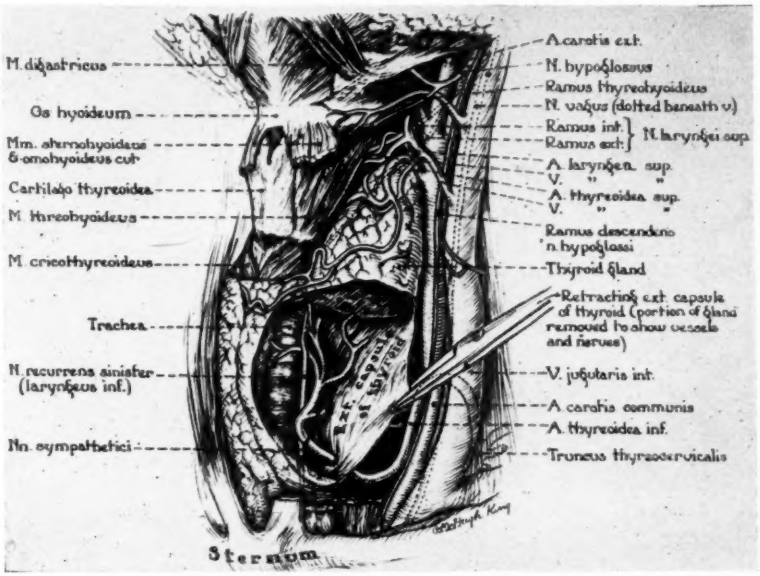

Fig. 1. Dissection of the right side of neck, to show the relations of the superior thyroid artery to the upper pole, together with the tracheal relation of the recurrent laryngeal nerve.

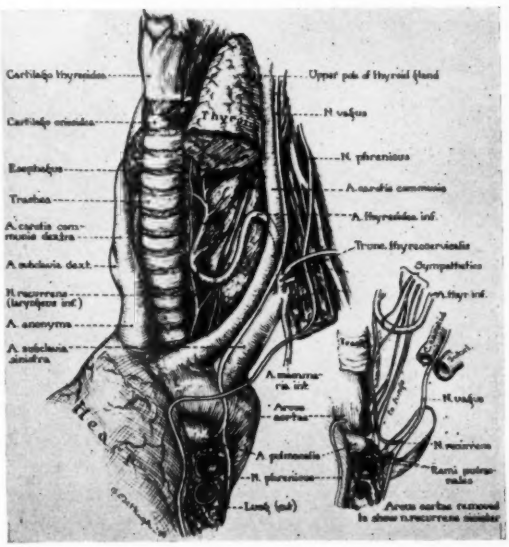

Fig. 2. Dissection of the left side of neck, to show the anatomical relations of the left recurrent laryngeal nerve and inferior thyroid artery.

will be discussed, namely, the diagnosis, the anesthesia, the position of the patient, special instruments, the incision, efficient hemostasis, drainage, and closure of the wound.

The diagnosis of the thyroid disturbance determines the choice of the operative procedure. The

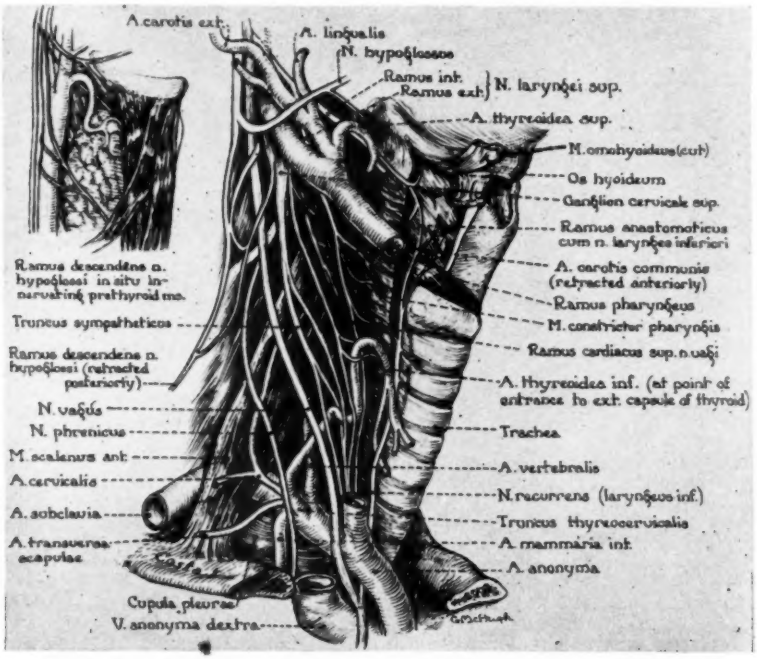

Fig. 3. Dissection of the neck, left side, to show the relations of the laryngeal nerves, thyroid arteries and capsule of the gland.

method of surgical attack might vary, according to the presence of:

(1) Diffuse goiter
(hyperthyroidism, with or without exophthalmos)

(2) Nodular goiter
(toxic or non-toxic)
(a) Preoperative affections of the laryngeal nerves.
(b) Deviation of the trachea.

In the surgical treatment of hyperthyroidism, application of ligatures to the thyroid vessels plays an important part. This is particularly true in the surgical management of hyperthyroidism in children. Hyperthyroid patients under fifteen years of age are particularly sensitive to surgical operations. They do not respond to Lugol's treatment as well as the adult, and the basal metabolic determination cannot be depended upon as accurately as in the adult. In children, we make a preliminary ligation of the two superior thyroid arteries, one week apart, followed by excision of the gland, two or three months later.

From our experience, which corresponds to the opinion of Reinhoff, we find about 5 per cent of all adults with hyperthroidism (without adenoma) do not respond to the treatment with Lugol's solution. This group must also be treated with preliminary ligation of the superior thyroid vessels. The operation of preliminary ligation of the superior thyroid artery is simple and is performed as originally described by Kocher (Fig. 5).

Preoperative affections of the laryngeal nerves, according to Reinhoff, occur in from 5 to 10 per cent of all simple goiters. In malignant goiters, the incidence is much higher. Preliminary laryngoscopic examination is very important in all cases of goiter, but especially so before operation on the large nodular goiter. The percentage of operative injuries to the recurrent laryngeal nerve varies from 1 to 5 per cent, and depends to a great extent on the type of the case

and the technic employed. Obviously, it is important to know if preoperative cord paralysis exists and to know which cord is affected.

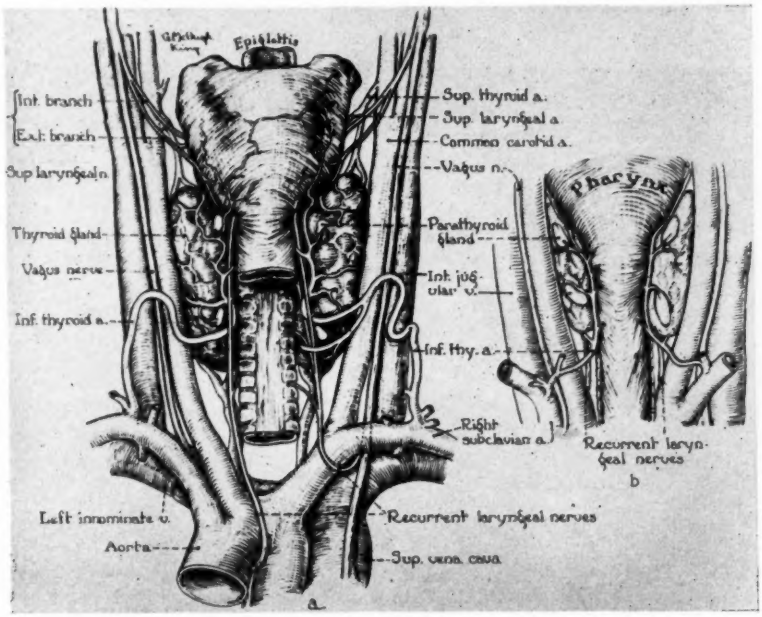

Fig. 4. Posterior view of the larynx and trachea, to show the anatomical relations of the laryngeal nerves to the thyroid arteries and parathyroids.

Deviation of the trachea is quite common in patients with nodular goiters, particularly in those with extreme enlargement of one lobe (Fig. 6). An X-ray examination of the neck and upper chest is, therefore, very important. Accidental injury to the trachea, as well as injury to the laryngeal nerves will often be avoided with this precaution.

The anesthesia to be used in the surgery of the thyroid has been much discussed. We find gas (nitrous oxide or ethylene) the ideal anesthetic for patients with marked hyperthyroidism. Nervousness in the patient is thus avoided and better relaxation of the patient is obtained. With the elimination of the psychic factor, we are better able to judge the condition of the patient, as indicated by the pulse rate, and thus to determine the extent of the operation. Local anesthesia or gas or a combination of both may be used in the non-toxic cases.

The position of the patient, during the operation (Fig. 7) is a matter of great importance. The head must be well extended backwards, but should be limited to the articulations of the upper vertebræ. This posture is indispensable in most patients with large goiters and makes the operation simpler and safer.

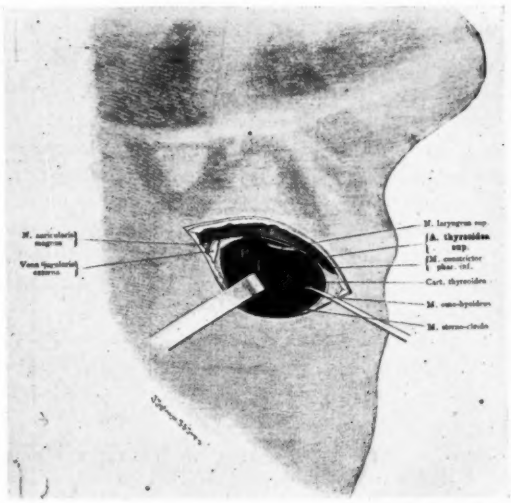

Fig. 5. Ligature of the superior thyroid artery. (From Kocher.)

Special instruments for goiter operations become more important as the operator attempts to save small muscles and to make preliminary ligations of the blood vessels. Unless appropriate retractors are employed, it is useless to attempt primary ligature of the inferior thyroid artery. A self-retaining retractor, ligature carriers and grasping forceps are very important (Fig. 8).

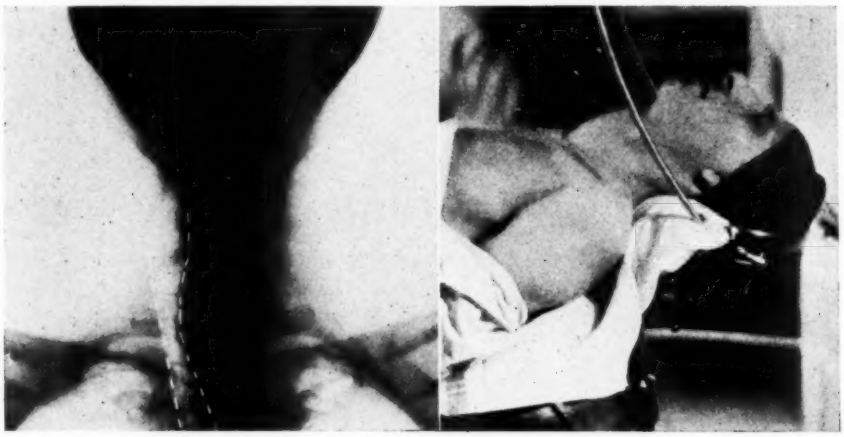

Fig. 6 *(left)*. Showing marked deviations of the trachea in large goiter.
Fig. 7 *(right)*. Showing the extension of the head for thyroidectomy.

The incision should be relatively straight and in cases of ordinary sized goiters should be placed about one finger-breadth above the upper border of the mesial ends of the clavicles. The larger the goiter, the higher the incision should be, because, with the excess of loose skin, the scar has a tendency to drop onto the upper chest. We include the superficial layer of the deep cervical fascia in our incision and this layer, together with the anterior jugular veins, is dissected back with the anterior flap (Fig. 9). The prethyroid muscles are thus exposed and, without their fascial investment, they can readily be retracted without cutting. As a further advantage of this deeper incision, ecchymosis in the flap is prevented in the thin patient.

Efficient hemostasis is most important in thyroid surgery. For better hemostasis and because of the greater safety to the recurrent laryngeal nerves and the parathyroids, we apply a ligature to the inferior thyroid artery, extrafascially, before proceeding to the excision of the gland. We always ligate one inferior thyroid artery and both superiors in non-toxic and mildly toxic cases. We ligate all four arteries in severely toxic cases. Pemberton states that he now ligates one or both inferior thyroid arteries in about 90 per cent of all thyroidectomies.

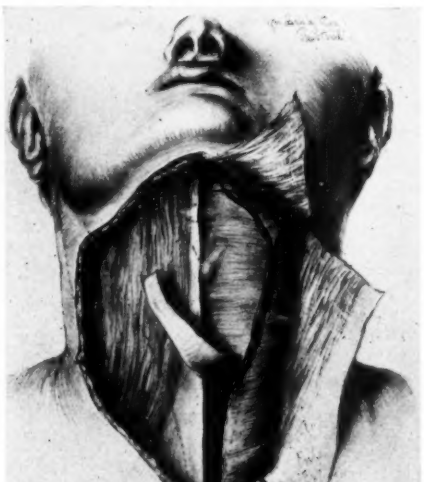

Fig. 9. Dissection showing the oblique passage of the anterior jugular vein through the deep cervical fascia.

The technic of extrafascial ligation of the inferior thyroid artery is as follows: After the usual incision, the median border of the sternomastoid muscle is liberated and drawn outward with a blunt retractor. The exposed fascia of

the prethyroid muscle is now slit vertically about 3 cm. in extent. The outer edge is pared back gently and the finger is easily slipped down to the transverse processes of the vertebra, mesial to the within outward, with curved forceps or a special ligature carrier (Fig. 8). Polar ligation will more often avoid accident to the superior laryngeal nerve than ultra ligation (Fig. 1). Goetsch,

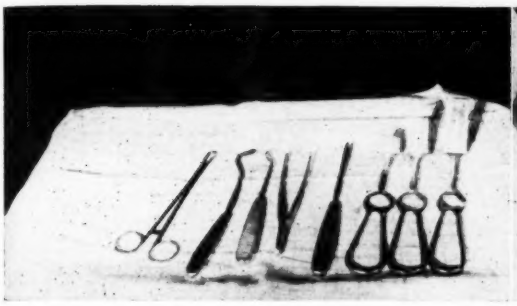

Fig. 8. Instruments necessary for primary ligature of inferior thyroid artery.

Fig. 10. Primary extrafascial exposure, and application of ligature to the inferior thyroid artery in thyroidectomy.

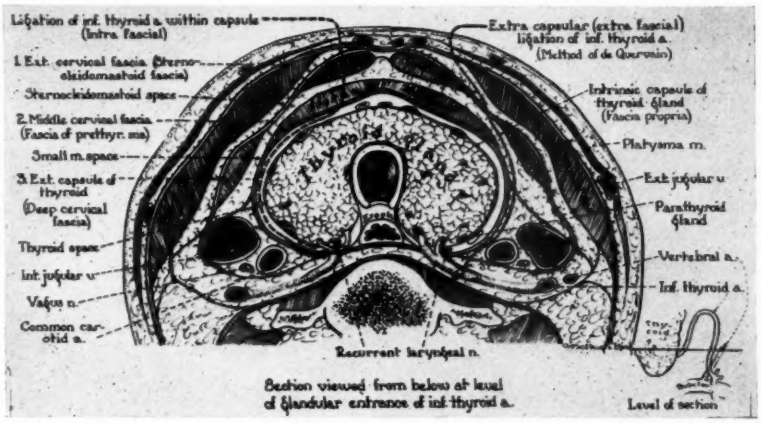

Fig. 11. Transverse section of the neck viewed from below to illustrate clinical application of ligatures to the inferior thyroid artery, based on the anatomical relations.

carotid sheath. The inferior thyroid artery is felt at the level of the sixth cervical vertebra, (usually marked by a small tubercle) as it emerges at right angles to the carotid vessels. With retractors properly placed, the artery is easily ligated (with linen). (Figs. 10 and 11.)

Ligation of the superior pole, in thyroidectomy, is easily performed with good exposure. After separation of the prethyroid muscles, we expose the upper pole and ligate en masse. Linen is used in toxic cases. The ligature must pass around the whole pole and not through it. This is best accomplished by passing the ligature from in a study of the histological changes in the arteries in patients with hyperthyroidism, found parathyroid bodies often on the superior thyroid vessels. Besides preserving these glands, it will also permit preservation of the healthiest part of the gland in the non-toxic cases.

After the preliminary ligation of the arteries, as described, the actual excision of the lobe is now performed with very little bleeding, thereby protecting the parathyroids and the laryngeal nerves. Because of the mesial relation of the recurrent laryngeal nerve to the gland (Figs. 2 and 3), excision is carried from within outward,

preserving the postero-mesial portion. This more definitely protects the nerve.

Drainage should be used in all thyroidectomies. Drainage of the flap is more important than drainage of the thyroid space. If it is not performed primarily, it will be necessary later. The tubes may be removed any time after twenty-four hours. In substernal and intrathoracic goiters, the tube should be kept in place three to six days, to avoid mediastinitis. To avoid "tracheal tug" lateral drainage is the method of choice.

Closure of the wound is made with interrupted No. 1 plain catgut sutures in the capsule of the gland and for uniting the edges of the prethyroid muscles. The incision in the fascia is repaired in the same manner. The skin is closed with clips and dermal. For a good scar (a very important part of the operation) the clips and dermal should be removed early.

CONCLUSIONS

Surgery of the thyroid is very safe when the operator is adequately informed and takes proper precautions. Adequate knowledge of the anatomy and proper hemostasis make possible a neat, clean, practical operation, offering protection to the laryngeal nerves and parathyroid bodies. Proper hemostasis prevents postoperative hemorrhage and makes less drainage, more rapid convalescence, a better scar and a greater chance of a permanent cure.

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EXTRA-UTERINE PREGNANCY*

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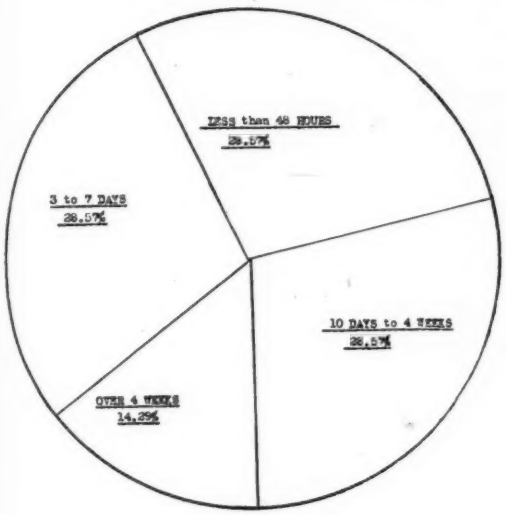
IT is our carefully considered opinion that far too often, extra-uterine pregnancies are not diagnosed early enough to give the patient the best possible chance for recovery. When we consider that the mortality ranges from 2 to 6 per cent, we cannot fail to recognize the importance of an early diagnosis. In this report of fifty-three cases, we had one death, which we feel could have been avoided, had the patient come to us before severe peritonitis had set in. Another patient seen in consultation had a leukocyte count of 45,500, which is the highest we have seen, and this woman also, needlessly, passed into the "Great Beyond." In this paper, we shall try to interest the profession in the making of an earlier diagnosis of extra-uterine pregnancy, and in this way try to do our share in contributing to the lessening of the mortality from this all too common source.

In this type of pregnancy the fertilized ovum becomes implanted at some point in its path between the ovary and the uterus, and in the great majority of cases it is arrested in some portion of the Fallopian tube. Thus it may be implanted in the ampulla, isthmus or very rarely in the portion passing through the uterine cornu—desig-

*Read before the annual meeting of the Minnesota State Medical Association, St. Paul, May 24, 1932.

nated interstitial pregnancy. It may also occur in the horn of a bicornate uterus. Primary abdominal pregnancy is reported, though it must be exceedingly rare, and the question must be

TIME ELAPSED FROM ONSET OF SYMPTOMS UNTIL PATIENT CONSULTED SURGEON GROUPED BY CONVENIENT CLASSES AND SHOWN BY PERCENTAGES



considered as to whether or not such a condition is not the result of an extruded tubal pregnancy. Litzenberg does not believe primary abdominal pregnancy can occur.

The varieties and results of ectopic or extra-uterine pregnancy may according to Lea be tabulated as follows:

I. *Ovarian Pregnancy:* Sac develops in substance of ovary, usually with early rupture.

II. *Tubal Gestation:* In the (1) isthmus; (2) ampulla; (3) accessory Fallopian tube (rare); fimbria (rare).
   A. At times it progresses in the Fallopian tube to advanced stage of pregnancy without rupture, but this is very rare.
   B. Intra-peritoneal rupture, most common, results in:
      1. Death from profuse bleeding;
      2. Hematocele, which may undergo
         a. Absorption,
         b. Suppuration.
      3. Fetus may develop in peritoneal cavity, placenta remaining in tube (secondary abdominal pregnancy). May go to full term, or sac may rupture at any time. Fetus may undergo secondary changes as: a. mummification; b. adiopocere; c. calcification; d. suppuration.
   C. Tubal abortion. Expulsion through abdominal ostium may result before occlusion occurs, *i.e.*, before eight weeks, may persist as a tubal mole and is of two types:
      1. Complete expulsion known as hematocele.
      2. Incomplete with recurrent intra-peritoneal hemorrhage: often fatal.
   D. Hematosalpinx. Death of embryo with rupture; tube filled with blood clot may become infected—pyosalpinx.
   E. Rupture Into Broad Ligament.
      1. May continue to develop till term, as an intraligamentous pregnancy.
      2. May develop for a time and then "secondary" rupture into peritoneum occurs.
      3. May form a hematoma, following death of fetus, and results in: a. absorption; b. suppuration.
      4. Suppuration of gestation sac. Rupture may occur into: a. bowel; b. bladder; c. vagina; d. abdominal wall.

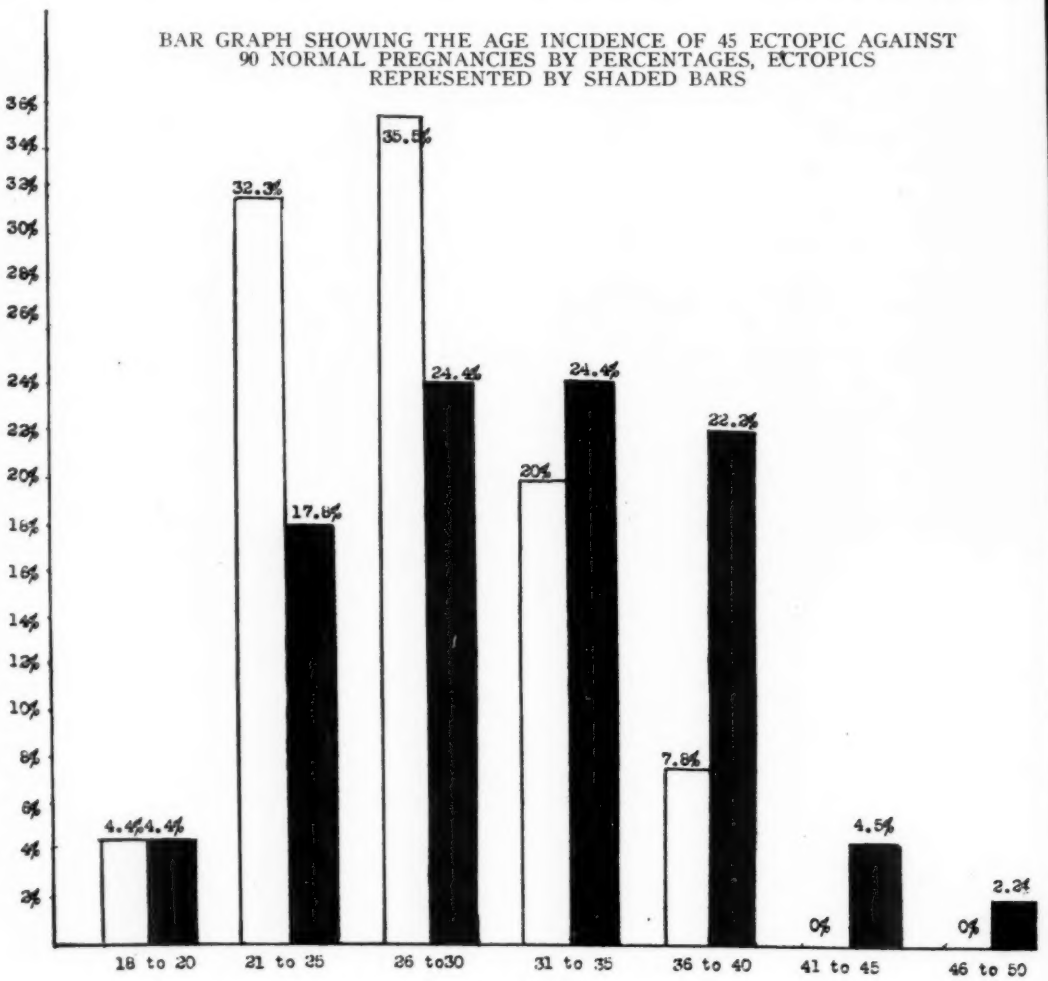
III. *Interstital Pregnancy.* Develops in portion of tube in uterine wall. Sac ruptures fourth month of pregnancy into: a. peritoneal cavity (may be fatal from hemorrhage); b. uterine cavity (rare).

IV. *Cornual Pregnancy.* This is rare and ends in intra-peritoneal rupture after third month.

V. *Primary Abdominal Pregnancy.* This is very rare.

Inasmuch as extra-uterine pregnancy is a disease occuring in the child-bearing period, its age incidence is necessarily limited (Graph I). In our own cases, we found 45 per cent occurring in the fourth decade and 37 per cent in the third. Seven cases occurred in the fifth decade, the oldest patient being forty-nine years of age, the mother of nine children. Our youngest patient was eighteen years old and had one child three months old. I think we may safely state that no time in the conceptive period of a woman's life

is exempt though the most frequent incidence is during the most active period of child-bearing, that is between 24 and 33 years. Wynne found 61 per cent of 303 cases in this decade; Farrar



GRAPH I

nancy resulted. She was operated upon and the tube removed but since this time she has borne four children safely and normally. One of our patients had had an ectopic pregnancy elsewhere some years before coming to the clinic, when a second tubal pregnancy was diagnosed on the opposite side. In the meantime, however, she had had one child, with a normal pregnancy and delivery.

63 per cent; Schumman 70 per cent. Fifty-five per cent of our cases occurred in this decade.

We operated upon one patient twice for extra-uterine pregnancy. At the age of twenty-four she had a pregnancy in the right tube, and at thirty-four one in the left tube. This brings up the question of whether or not we should take out the unimpregnated tube at the first operation. My personal opinion is *no*, as the following case will demonstrate. A patient became pregnant soon after marriage and a tubal preg-

One of our patients had a right sided hematosalpinx with a left sided extra-uterine pregnancy.

We have had two cases of abdominal pregnancy with a non-viable child. In one the placenta was attached to the omentum and loops

of intestines, and in the other case there was a placental attachment to the tube. The fetus was free in the abdominal cavity.

Two of our patients had, we believe, ovarian pregnancies, though neither was proven.

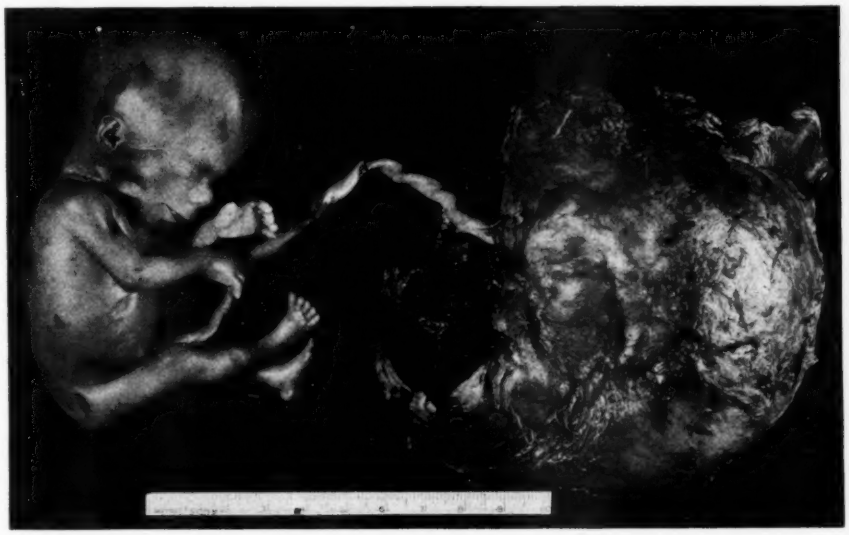


Fig. 1. Questionable tubo-ovarian pregnancy, unruptured.

One case (Fig. 1) is a questionable tubo-ovarian pregnancy that is now being further investigated at the University of Minnesota. This was an unruptured right-sided pregnancy.

One of our cases was that of an interstitial pregnancy where it was necessary to do a hysterectomy.

In this report covering a series of fifty-three cases, there has been one death, as mentioned above.

Frequency.—All old statistics regarding the frequency of extra-uterine pregnancy range from one in five hundred to one in twelve hundred pregnancies. At present I think the frequency is considered about one in three hundred.

In order to find out the incidence in the Twin Cities, the writer consulted the records of the hospitals of the Twin Cities as to the number of births, miscarriages and extra-uterine pregnancies, entered and treated during the years 1926 to 1931 inclusive. The Department of Health records of the Twin Cities were consulted also with the idea of obtaining the relative proportion of labor cases hospitalized, and we found deliveries at the Minneapolis Hospitals were 71 plus per cent of the total and we felt that the home treatment of abortions and miscarriages would in all probability approximate the same ratio and in this way, and from these figures, we could derive the total number of intra-uterine pregnancies. A similar study was made of St. Paul, where we found the hospitalized cases of obstetrics were 72 plus per cent of the total. Our findings give us approximately the following figures:

Minneapolis Health Office:	
Births	48,129
Stillbirths	1,853
Miscarriages	4,867
Minneapolis Hospitals:	
Births	39,580
Miscarriages	3,981
Ectopics	412
St. Paul Health Office:	
Births	31,341
Miscarriages	3,698
Stillbirths	1,098
St. Paul Hospitals:	
Births	23,583
Miscarriages	2,777
Ectopics	268

The total number of miscarriages throughout

the cities of Minneapolis and St. Paul must of necessity be approximated on a ratio basis but we feel that these figures are quite reasonably accurate.

Symptoms.—These are interesting and valuable (Graph IV). The writer believes the most valuable single item is the history. Early tubal pregnancy differs very little from a normal preg-

MINNEAPOLIS

HOSPITALS				HEALTH OFFICE				
Year	Deliveries	Miscarriages and Abortions	Ectopics	Living Births	Still-births	Calculated Abortions	Total Pregnancies	Pregnancies per Ectopic
1926	6,391	624	87	9,192	319	911	10,422	120
1927	6,682	652	50	8,630	304	842	9,776	195
1928	6,486	656	73	8,348	376	844	9,568	131
1929	6,391	705	67	6,945	310	782	8,037	120
1930	6,845	620	77	7,037	270	637	7,944	103
1931	6,785	724	58	7,977	274	851	9,102	157
Total	39,580	3,981	412	48,129	1,853	4,867	54,849	133
Ect. P.	412— 11 deaths—2.6%		1:37					
Ut. P.	54,849—286 deaths—0.52%		1:192					

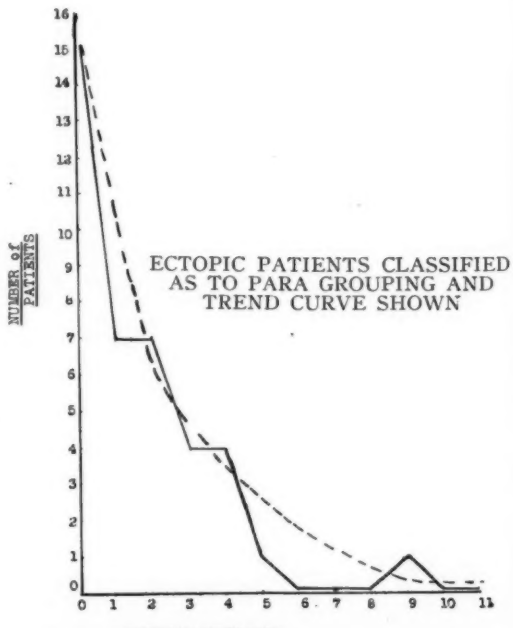
SAINT PAUL

HOSPITALS				HEALTH OFFICE				
Year	Deliveries	Miscarriages and Abortions	Ectopics	Living Births	Still-births	Calculated Abortions	Total Pregnancies	Pregnancies per Ectopic
1926	4,022	476	53	5,660	211	655	6,526	123
1927	4,064	460	34	5,463	183	618	6,264	184
1928	3,771	441	42	5,112	168	597	5,877	140
1929	3,902	481	41	5,149	171	660	5,980	145
1930	3,965	456	52	5,074	196	583	5,853	112
1931	3,859	463	46	4,883	169	585	5,637	123
Total	23,583	2,777	268	31,341	1,098	3,698	36,137	134
Ect. P.	268—11 deaths—4.1%		1:24					
Ut. P.	36,137—125 deaths—0.34%		1:289					

From this study and these figures—in Minneapolis we find the incidence of extra-uterine pregnancy as compared to intra-uterine pregnancy to be one in 133; in St. Paul, one in 134. The mortality rate was 2.6 per cent for Minneapolis and 4.1 per cent for St. Paul.

In our cases the ectopic pregnancies were right-sided in 62 per cent and left-sided in 38 per cent. This closely corresponds to the location of pain as shown in Graph III.

A drop in the hemoglobin usually accompanies either intra- or extraperitoneal hemorrhage. The lowest hemoglobin recorded in this series was 40 per cent; the highest 90 per cent (usual hemoglobin 70 to 75 per cent). The red cell count is of little value and is usually in direct ratio to the hemoglobin. More important however is the white count, which, in most cases of intra-abdominal hemorrhage, is accompanied by an increase in the leukocytes and a relative increase in the polymorphonuclears. The count most often ranges between 12,000 and 15,000. Our lowest white count, however, was 4,400, while our highest was 45,500.

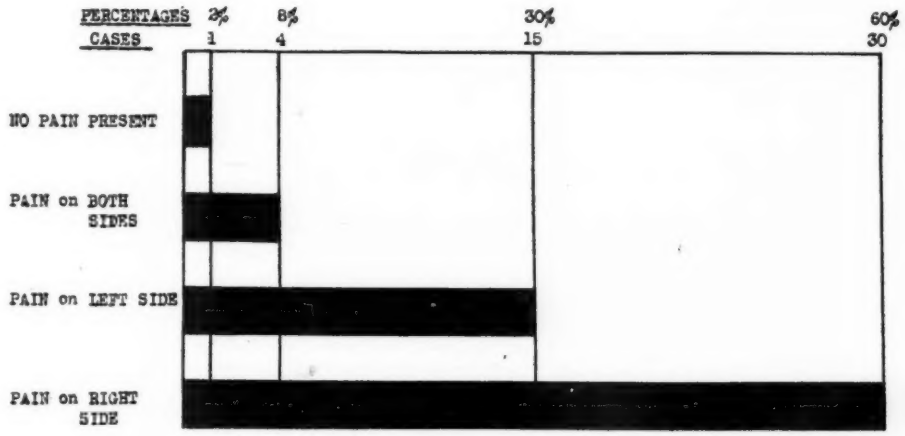


GRAPH II

nancy and to diagnose a case of extra-uterine pregnancy before rupture is rarely possible. It has been our good fortune to recognize one such case, in consultation with Dr. Litzenberg, which risk of recurring hemorrhage with pain and shock.

Diagnosis at times may be uncertain. If the patient presents the symptoms of early gestation

LOCATION OF PAIN IN ECTOPIC PREGNANCIES: 50 CASES



GRAPH III

was proven by operation. This, he says, was the earliest case he has seen.

A history of amenorrhea for one or more periods is usual though cases do occur where menstruation has been regular. When rupture occurs, the patient experiences pain in abdomen and frequently faints or feels faint. There is usually also pallor, rapid breathing and increased pulse rate. This may be due to rupture of a tube or to a tubal abortion and it may be difficult at this stage to differentiate between them. Usually as a concomitant symptom, there is some slight or even severe bleeding from the uterus with expulsion of the whole or parts of the decidua.

On pelvic examination the uterus feels softened and is pushed to the side of the normal tube. A tender boggy mass is felt on the side involved, and often we have found a symptom which is rarely described, namely, a definite fullness or pressure or pain in the rectum with an urge to move the bowels. This symptom was present in 56 per cent of our cases. Vomiting may be a symptom; temperature and pulse may be elevated. All symptoms may abate and the effusion may become encysted. There is always a grave and a unilateral swelling is found in the pelvis, the history of pain, shock (rapid pulse and respiration), and bleeding from the vagina, extra-uterine pregnancy must be considered and disproven, bearing in mind always that old inflammatory conditions of the tubes or ovaries or the presence of an ovarian cyst with twisted pedicle may give rise to symptoms closely simulating extra-uterine pregnancy. An accurate diagnosis can often be made only by abdominal exploration.

A history of lower abdominal pain, whether severe or not, of faintness or actual syncope, one or more missed periods, and the presence of pallor, rapid pulse and respiration, are practically pathognomonic of a ruptured extra-uterine pregnancy and, if confirmed by pelvic findings, operation is imperative.

SUMMARY

This report of fifty-three cases of extra-uterine pregnancy is presented with the idea of interesting the profession in the earlier diagnosis and treatment of this condition, in this way de-

creasing its mortality. We feel there should be no significant mortality if the diagnosis is made early.

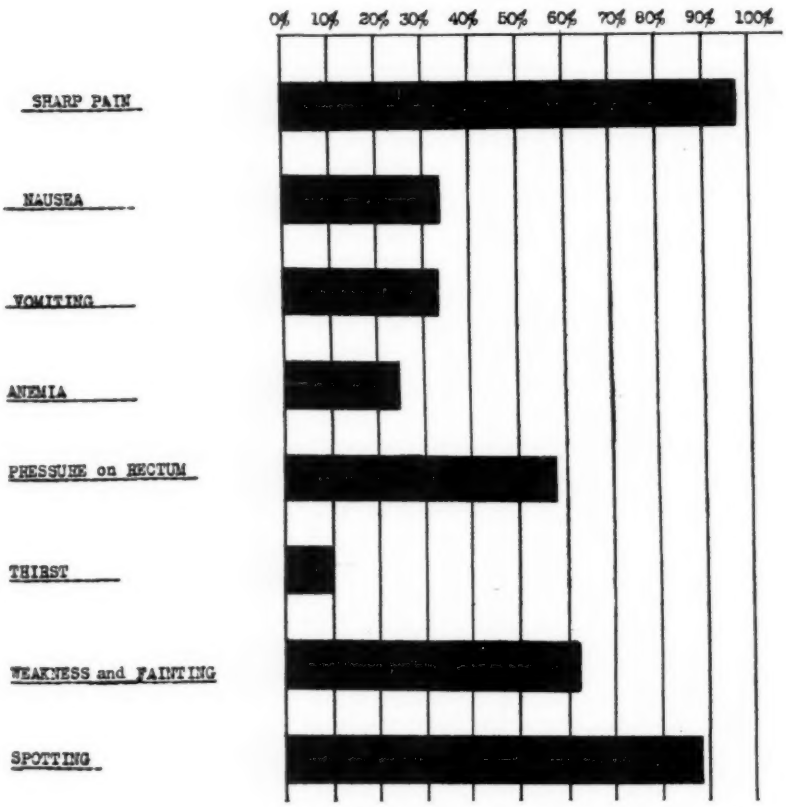
A general résumé of the types and the incidence of extra-uterine pregnancy is given. We find that the frequency is higher than most authorities would lead us to believe.

A study of the vital health statistics over a six year period in the cities of St. Paul and Minneapolis showed an incidence of one ectopic pregnancy to 133 intra-uterine pregnancies in Minneapolis, and one to 134 in St. Paul.

The decade in which we found the greatest incidence corresponds to the most active child-bearing period, namely, between the ages of twenty-four and thirty-three (55 per cent).

In this series there were two cases of abdominal pregnancy with a non-viable child. Two cases were believed to be ovarian, one tubo-ovarian, one interstitial, showing that various types may be found in even a small series of cases.

SYMPTOMS OCCURRING WITH ECTOPIC PREGNANCIES SHOWN BY A PERCENTAGE RATIO OF THE TOTAL NUMBER OF CASES



GRAPH IV

The presence of a leukocytosis is a very important consideration, most cases showing an increase ranging from normal to 28,600, with an average of 12,000 to 15,000.

The most important diagnostic criteria are: (1) history of missed menstruation; (2) lower abdominal pain, severe or slight; (3) vaginal bleeding; (4) presence of a pelvic mass. These findings plus pallor, shock or actual fainting, we believe are usually pathognomonic of a ruptured extra-uterine pregnancy. Pain or pressure on the rectum is a symptom which was found in 56 per cent of our cases, and which we believe to be of diagnostic value.

BACTERIOPHAGE IN THE TREATMENT OF OSTEOMYELITIS*

A STUDY OF TEN CASES, INCLUDING THREE CASES COMPLICATED BY STAPHYLOCOCCUS AUREUS SEPTICEMIA

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and
MARGARET KELLER, M.S.
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AN opportunity was offered to the Department of Surgery at the Michigan University Hospital to study the effect of bacteriophage on osteomyelitic wounds. Since the use of bacteriophage as a therapeutic agent in surgery is comparatively new, especially in the treatment of osteomyelitis, it was thought best to limit the number of cases in this study to a relatively small group. Accordingly, ten cases, representing the usual variety of osteomyelitic cases seen at the hospital, were selected. After about eighteen months of observation of these wounds, it was believed that a preliminary report would be justifiable.

The infecting organism in osteomyelitis is most often the Staphylococcus aureus. Excellent results are reported in the use of staphylococcus bacteriophage for other staphylococcic infections, *i.e.*, acne, furunculosis, carbuncles, sycosis, subcutaneous abscesses, pyelonephritic abscesses, etc. (Bruynoghe and Maisin,[1] Bazy,[2] Barboza,[3] Hauduroy, Camus, and Dalsace,[4] Rice,[5] McKinley,[6] Larkum[7] and others.) It was thought that this bacteriophage might also be successful in the treatment of osteomyelitis.

The use of bacteriophage for osteomyelitis has been rather limited. Claeys and Peyre[8] report a case of a child with acute osteomyelitis of the ribs who was cured in forty days by the local application of an auto-bacteriophage to the wound following operation. They also report the case of an adult who had had chronic osteomyelitis of the right femur since the age of twelve and had had fourteen previous operations. Cure was obtained in less than five months following the application of the autobacteriophage to the wound. Delbet, Mocquot and Mornard[9] report two cases of osteitis treated by "vaccino-therapie-locale." Both were cases of persistent fistulæ following operations on osteomyelitis of the tibia. "Le propidon" was used in the fistulæ in doses of 4 c.c. at two-day intervals. In one case the fistula remained closed after three months. In the second case the fistula closed rapidly with the treatment, but reopened after one and a half months. A new operation again left a fistula. These investigators make the observation that where there is necrosed bone, "vaccino-therapie" alone will not effect a cure. Rice[5] makes a similar observation in reporting eleven cases of osteomyelitis treated by bacteriophage with four excellent results, three fair results and no effect in four. If there was dead bone in the lesion, the bacteriophage was apparently of no avail. When all necrotic bone was removed, good results were obtained. McKinley[6] reports four cases of osteomyelitis with rapid healings following the use of bacteriophage injected into and about the wound. One of his cases showed a sequestrum by X-ray examination.

Bacteriophage has been in use at the University Hospital since 1929. It has been used mainly in infections due to B. coli or staphylococci, though it has also been used against B. typhosus and paratyphosus, B. dysenteriæ and the streptococcus. The bacteriophage used in this study was the Gratia H. Strain for staphylococci. This was furnished by the Department of Clinical Laboratories of this hospital and was prepared in accordance with a method described elsewhere.[10] We did not use the mixed bacteriophage used by Rice in his series of cases.

Of the ten cases treated, three were cases of acute osteomyelitis complicated by a staphylococcus aureus septicemia. There was one case of subacute osteomyelitis of eighteen days' duration. One case was an osteomyelitis developing in a Steinman pin wound while under treatment in the hospital. The remaining five cases were of chronic osteomyelitis with a duration of two

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months to five years, all of whom entered with draining sinuses, sequestra, or soft tissue abscesses following a recent exacerbation of the chronic process.

In all of the cases, sufficient saucerization was done, adequate immobilization was maintained, and general supportive measures were given. The wounds were cultured at operation and the organisms obtained were tested for lysis in vitro with the bacteriophage in use. In only one case were the organisms not lysed in vitro by the bacteriophage and in this case an autobacteriophage was prepared.

In three cases (Cases 1, 2, 3) dressings moistened with bacteriophage were used. The usual procedure in these cases was: Following the saucerization, gauze packs wet with the bacteriophage were packed into the wound. Every four to ten days a dressing was done. At the time of the dressing, precautions were used to maintain asepsis as far as any outside contamination was concerned. The skin about the wound was cleansed with alcohol, being careful not to get any alcohol into the wound itself, and no other disinfectant was used. The packing was removed from the wound and fresh gauze packs moistened in bacteriophage were inserted. In several of the cases bacteriophage was not used at the beginning of the treatment of the wound but was instituted after a second operation or at the first dressing following the operation, acriflavine or vaseline packs being used originally.

In four cases of this series subcutaneous or intramuscular injections of bacteriophage were used in addition to the dressings moistened with bacteriophage. The injections were given in 1 to 3 c.c. doses at intervals of twenty-four to forty-eight hours. One or two injections were used.

In three cases bacteriophage was given intravenously in 3 to 5 c.c. amounts in addition to the bacteriophage dressings in the wounds. One or two injections were given at intervals of twenty-four hours to five days. In one case this series of injections was repeated after an interval of two months.

The cases have been grouped according to the manner of treatment. The following three cases were treated with bacteriophage dressings alone.

Case 1.—A boy of eleven years with chronic osteomyelitis of the entire shaft of the left tibia. He had had a saucerization and an incision and drainage of a large abscess. Eight weeks after admission he had a sequestrectomy and at this time the bacteriophage was started. The culture at operation was Staphylococcus aureus, Streptococcus hemolyticus, and B. mucosus capsulatus. His strain of Staphylococcus aureus was resistant to the Gratia H. Strain bacteriophage but was lysed in vitro by a bacteriophage prepared for it. However, the wound appeared necrotic and after three dressings at intervals of five to eight days the bacteriophage was discontinued.

Case 2.—A boy of ten years who had fractured both femora in an automobile accident and entered the hospital in shock. He developed many complications, including a "coccus kidney," measles, chicken-pox and tonsillitis; also an osteomyelitis at the site of insertion of the Steinman pin in the right femur. This wound was irrigated with bacteriophage when dressings were done, but as no improvement was noted and X-ray demonstrated a definite bone abscess, a local saucerization was done. Following this the patient developed an erysipeloid reaction and was treated as for erysipelas and the bacteriophage discontinued. The culture showed Staphylococcus aureus and Streptococcus hemolyticus.

Case 3 was a boy of seven years with a severe osteomyelitic process involving the lower two-thirds of the left femur. A very radical saucerization was necessary, at which time the entire lower end of the femur was removed. Following this operation, bacteriophage packs were used and these were irrigated with bacteriophage through Dakin's tubes. Unfortunately the wound became secondarily infected with B. pyocyaneus, against which the bacteriophage had no effect. Therefore irrigations were changed to 0.5 per cent acetic acid and later to Dakin's solution. It was necessary to perform a mid-thigh amputation later.

The following four cases were treated with subcutaneous or intramuscular injections in addition to dressings of bacteriophage.

Case 4.—A girl of four years with osteomyelitis of the entire left tibia of about eighteen days' duration. An operation had been performed before her entrance to the hospital. On admission, X-ray showed sequestration of the entire shaft of the tibia. A more radical operation was performed and bacteriophage dressings were done at intervals of four to six days and two subcutaneous injections of bacteriophage of 1 c.c. each at a forty-eight hour interval were given. The child showed rapid improvement in general health. Sequestra were obtained from the wound occasionally and at the end of three and a half months the wound was nearly healed. At six months the incision was entirely healed and the child was able to go about without additional support to the tibia. Subsequent examinations have been negative.

Case 5.—A girl of thirteen years who had an acute exacerbation of an old chronic osteomyelitis of the lower third of the left femur. A large subperiosteal abscess was drained and saucerization of the left femur was done. Further saucerization was necessary, which

left a mere shell over the condyles of the femur and a very thin portion of bone posteriorly. Bacteriophage dressings were instituted just previous to this last operation and were used consistently afterwards. Acriflavine was used on the original dressings. One injection of 1 c.c. of bacteriophage was given intramuscularly. During one change of dressing, a large sequestrum was removed and a pathologic fracture was noted at the point where the sequestrum had become separated. However, dressings were continued over a long period at intervals of five to seven days. The large wound gradually filled in and X-ray showed new bone formation filling in the defect. The wound was practically healed eight months after entrance to the hospital and the patient was upon a non-weight bearing walking caliper. She later refractured her leg and developed non-union at site of the fracture. A year and a half after her original admission, the area of non-union was operated upon.

Case 6.—A boy of twelve years who entered with multiple osteomyelitis involving the entire right femur with sequestration of the head of the femur, the lower two-thirds of the left femur with a pathological supracondylar fracture and a separation of the lower femoral epiphysis and the upper one-third of the right tibia. The general condition of the boy was very poor. Complete radical saucerization was impossible because of the extent of bone destruction. Sequestrectomies and sufficient saucerization to obtain drainage were done in stages. Vaseline dressings used originally were changed to bacteriophage dressings twelve days after the second operation and one month after admission, and these were maintained. Two injections of bacteriophage of 2 and 3 c.c., respectively, at forty-eight hour intervals were given subcutaneously. Although this boy is still under treatment, eleven months after admission a marked improvement is noted in the general condition and in the X-ray pictures.*

Case 7.—The fourth case to be treated with subcutaneous injections was a child of four years with multiple osteomyelitis involving practically every bone of the body, including the skull. Radical saucerizations of all foci except the skull were performed. Bacteriophage was twice injected subcutaneously in 1 c.c. doses at an interval of forty-eight hours. The wounds themselves were not consistently treated with bacteriophage. The child showed some general improvement though new foci continued to develop. The blood cultures were at all times negative. The child was subsequenlty discharged considerably improved. Later a letter stating that the child had died from meningitis was received at the hospital.

septicemia. All were critically ill at the time of admission five to seven days after the onset of acute symptoms. Incision and drainage of the foci were done as indicated and the bacteriophage dressings were applied to the wounds. Intravenous injections of bacteriophage were not made until after the septicemia had been diagnosed by blood culture except in the second case of this series, where the extreme condition of the patient seemed to warrant the treatment without waiting for the result of the blood culture.

Of the three patients treated by intravenous injections, in addition to dressings of bacteriophage all were complicated by a Staphylococcus aureus

All three patients had severe reactions following the administration of the bacteriophage intravenously. They showed dyspnea, cyanosis, and shallow respirations while having severe chills, and later they became very drowsy or delirious. However, in each of these cases the condition previous to administration of the bacteriophage was exceedingly poor, the temperatures were high and in none of the cases was there expectation of recovery. Two of these paients died. One is living. It is interesting to note the blood cultures in these three cases.

Case 8.—A boy of twelve years with a primary focus in the right ankle and metastatic foci in both clavicles, humeri and parotids. A summary of the blood cultures and intravenous treatment follows:

Blood culture taken	Reported	Result	Remarks
10-18-30	10-20-30	Staphy. aureus	3 c.c. bacteriophage IV given 10-20-30
10-20-30	10-22-30	Staph. aureus	3 c.c. bacteriophage IV given 10-22-30
10-21-30	10-23-30	Staph. aureus	
10-22-30	10-24-30	Staph. aureus	
10-23-30	10-30-30	No growth	After 7 days culture
10-24-30	10-31-30	No growth	After 7 days culture
10-25-30	10-31-30	Staph. aureus	After 6 days culture
10-30-30 (day of death)	11- 3-30	Slight growth	After 4 days culture

Although an autopsy was not obtained the terminal complications were diagnosed a diffuse pleuritis and pericarditis.

Case 9.—The second patient of this series was a boy of ten years with osteomyelitis of the right tibia. He entered the hospital dehydrated and irrational and was moribund throughout the short period in the hospital. A diagnosis of septicemia was made and he was given bacteriophage intravenously. A summary of the blood cultures and intravenous treatments follows:

Blood culture taken	Reported	Result	Remarks
1-19-31	1-21-31	Staphy. aureus	3 c.c. bacteriophage given 1-19-31 3 c.c. bacteriophage given 1-22-31

*Since this article was written this patient was given non-weight bearing walking calipers and is now up and about. He has full range of motion, left hip; ankylosis, left knee; limited motion, right knee and right hip. He still has draining sinuses in the lower third of the left thigh and at the upper end of the right tibia. He has gained weight and his general condition is very much improved.

1-21-31	2-2-31	Staph. aureus with slight growth of Pneumococcus type IV	10 days before growth appeared
1-23-31			death

It is noted that in each case the growth of the organism has been inhibited if not completely arrested.

Case 10.—The third case was a girl of fourteen years who entered with multiple septic joints. For five days after admission positive blood cultures were obtained. Two doses of 5 c.c. each of bacteriophage were given intravenously at an interval of 48 hours. For the six days following the initial injection positive blood cultures were obtained though the culture did not appear until after 48 or 72 hours, but on the seventh day negative blood cultures were obtained and check examinations during the next twenty days still showed negative cultures. However, the patient already had severe osteomyelitic processes in her left scapula, left humerus and left ilium as well as her many septic joints, both wrists, left elbow and left hip. Following an exacerbation of the process in her left ilium another blood culture was taken (exactly fifty-six days following the first negative blood culture). Two days later this was reported positive and four days later the patient was given a 3 c.c. injection of bacteriophage intravenously which was repeated after an interval of five days. Seven days after the first injection the blood cultures were again negative and remained so. Except for two very small abscesses the patient has remained quite well following her discharge from the hospital. At present the left hip and left elbow are ankylosed but she is able to attend school. It is only fair to state that during the acute stage of this disease the patient voluntarily took 5,000 to 13,000 c.c. of fluid per 24 hours and received four transfusions of whole blood.

DISCUSSION

So many factors enter into the treatment of an osteomyelitic case that it is difficult to evaluate the various therapeutic agents. The bacteriophage, although given prominence in this paper, was only one factor in the treatment of these cases. Its value cannot be judged so much by the ultimate outcome of the case as by the appearance of the wounds during treatment.

It was necessary to maintain absolute asepsis during the dressings of the wounds, as the bacteriophage while lytic to the staphylococcus has presumably no effect on other organisms. In those cases where the wound was secondarily infected with other organisms either before (Cases 1 and 2) or during (Case 3) the treatment, the bacteriophage seemed to have little or no effect and it was necessary to resort to other treatment. Particularly was this noted in those wounds where the streptococcus was present.

In those cases where the bacteriophage seemed to be of decided benefit (Cases 4, 5, 6 and 10), the wounds were treated systematically, and rapidly (at the time of the first dressing) presented unusually clean appearing, fine, red granulations. The discharge from the wounds was always copious and as the dressings were left undisturbed, in some cases longer than a week, they were often foul smelling. However, the wounds were not uncomfortable to the patient and there was a gradual improvement in the patient's general condition coinciding with the improvement in the wound.

In Case 7, there was improvement in the child's condition though the multiplicity of the lesions and the marked involvement of the skull made any treatment insufficient.

Severe septicemias existed in Cases 8 and 9 and the patients would no doubt have died regardless of any treatment. One lived twelve days and one four days after admission to the hospital. The wounds therefore were not under observation for any length of time and the only possible benefit attributable to the bacteriophage was the effect upon the organisms in the blood stream.

In this series of cases, no general symptoms were noted in those cases where the bacteriophage was used intravenously it was difficult to bacteriophage was given intramuscularly or subcutaneously, no reactions whatsoever occurred in two cases, whereas the other two showed swelling and redness at the site of the injection and the patients had mild chills and slight elevation of temperature about two hours following the injection. In the three cases where the bacteriophage was used intravenously it was difficult to determine what part of the picture might be considered a reaction. However, all three patients had severe chills and showed cyanosis and dyspnea for a period of several hours.

Of additional interest in this study was the finding, in those cases of osteomyelitis complicated by a Staphylococcus aureus septicemia, of a definite reduction of the organisms in the blood stream following the intravenous injection of bacteriophage. Although two of three septicemia patients died, the growth of the organisms from the blood had been inhibited before death occurred and it was thought that death in each case was due to other complications. In the one pa-

tient that survived, it was demonstrated on two occasions that the blood culture could become negative following the use of bacteriophage intravenously.

We find that intravenous injections of bacteriophage are condemned by most of the workers with bacteriophage. Maute[11] working with a "solution bacteriennes" used it intravenously with excellent results in staphylococcic infections and had no untoward effects.

Gosset[12] reports marked and rapid improvement in a patient having a diffuse phlegmon of the thigh without septicemia, who was treated by 5 c.c. bacteriophage diluted with physiological serum and given intravenously. His patient had a severe chill and elevation of temperature following the injection. Hauduroy[13] however states that bacteriophage should never be used intravenously because the product which one injects is a culture of bacteriophage in peptone water or broth and the introduction of peptone into the veins would give a general reaction which might be fatal. He also calls attention to the fact that treatment of septicemia is useless, perhaps because therapy is always started late. Rice[5] reports two patients with staphylococcus septicemia treated by subcutaneous injections of bacteriophage. Both patients died though one was moribund on admission and one lived weeks longer than was to be expected. Bacteriophage was not used intravenously because the effect of the peptone broth was feared.

SUMMARY

A study was made to test the therapeutic value of staphylococcus bacteriophage in the treatment of osteomyelitic wounds. Ten cases were studied. Of this number three had wounds which were infected with several types of organisms. These did not respond to the bacteriophage treatment although the bacteriophage was used on dressings only. Four patients having a pure culture of Staphylococcus aureus were treated by subcutaneous and intramuscular injections as well as by dressings, and three of these have shown good results. One died of meningitis due to osteomyelitis of the skull. The three remaining cases of osteomyelitis were complicated by Staphylococcus aureus septicemia and were treated by intravenous injections of the bacteriophage. Two of these patients died, one survived.

It would appear that the best response to bacteriophage therapy is obtained in those cases of staphylococcus osteomyelitis that are uncomplicated by the presence of other organisms or by septicemia. It should be mentioned that these uncomplicated cases of staphylococcus osteomyelitis are the ones that respond best to other methods of treatment.

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CASE REPORTS

AMPUTATION OF THUMB BY TORSION*

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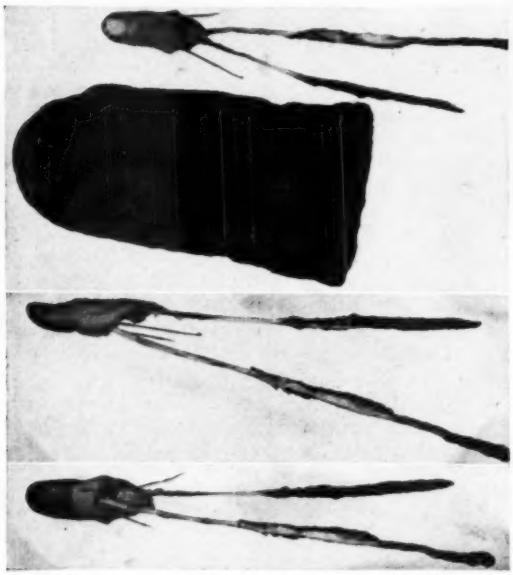
Minneapolis

A boy, eighteen years of age, while cranking a one cylinder engine with a detachable crank, caught the thumb of his mitten on the engaging key or pin on the crank-shaft as the engine started. There was a sudden painless wrenching sensation in his forearm as the glove was thrown to the ground by the revolving shaft. The fact that his thumb had been amputated rather than sprained (his first impression) was called to his attention by the sudden gush of blood from the stump. A bandage was applied to control the hemorrhage, and he was brought to the Minneapolis General Hospital at once by a friend. Before removing the dressings, the patient was asked how much of the thumb had been torn off. On replying that he did not know, the friend handed one of us the mitten the patient had worn, stating that he thought the part that had been torn off was still in it. Examination revealed a heavy pigskin mitten (Fig. 1) intact except for a slightly loosened seam along the outer surface of the thumb. In the thumb of the glove the amputated digit was found (Figs. 1, 2, and 3). To it were attached the flexor and extensor pollicis longus tendons which had been torn from their origins high in the forearm. Vessels and nerves also protruded outwards. An X-ray of the amputated digit was taken and is shown in Figure 4.



Figs. 1, 2 and 3

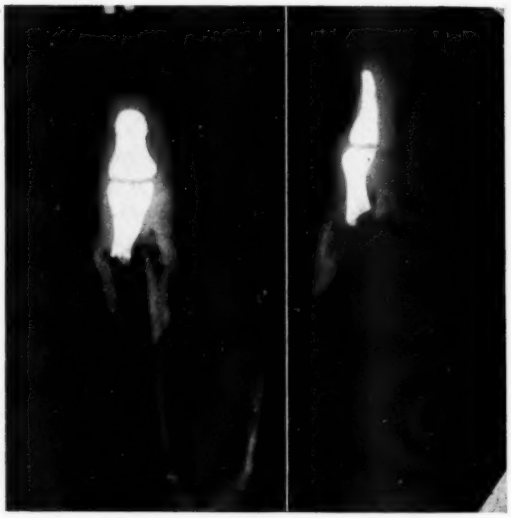


Fig. 4

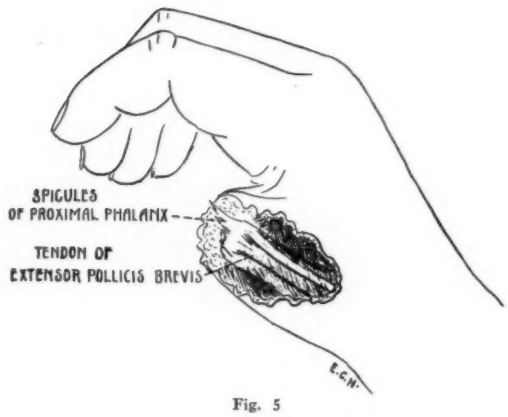
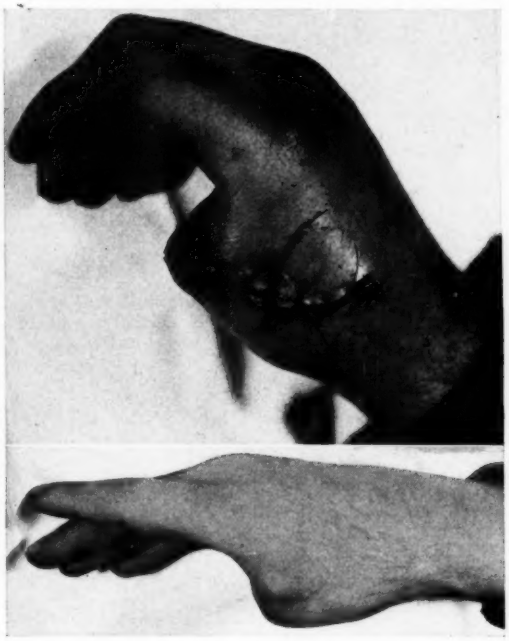


Fig. 5

*From the surgical department of the Minneapolis General Hospital.

After removing the bandage from the stump preparatory to operation, examination revealed a splintered, sharply pointed fragment of the proximal phalanx protruding through the torn tissues. The skin had been torn off obliquely from the base of the thumb anteriorly, to the metacarpo-carpal joint posteriorly (Fig. 5). A



Figs. 6 and 7

debridement was performed, the small projecting portion of the phalanx being removed. The fascia and skin were then closed primarily, using interrupted catgut and dermal sutures (Fig. 6).

Three months after the accident occurred, the boy returned in successful quest of the mitten shown in Figure 1. Examination of the hand at this time showed that the wound had healed by first intention with the result seen in Figure 7.

FOREIGN BODIES IN THE APPENDIX

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Grand Forks, N. D.

It is unfortunate that the old St. Luke Hospital records, the first hospital in the state of North Dakota, have been destroyed, and, therefore, it is impossible for us to tabulate the number of cases of offending objects found in the little organ at operation for the relief of inflammation where the foreign body was the primary cause. Fecoliths are not considered. Further, I can only approximately estimate the number of appendectomies I have performed, but it is considerably over two thousand.

The largest number of my patients in whom foreign bodies were found were those due to impaction of leaden pellets or goose shot in the lumen of the organ. In the late eighties geese were so plentiful on the Goose River and adjoining water courses, that farmers slaughtered the birds by the hundreds with the object of supplying their larder with meat for the whole season. Many farmers, during the migrating seasons, salted down two or three barrelsful of birds, supplying their meat wants for a year's time. Prairie chickens and grouse were also plentiful, and as they were shot in season and out of season, they also were killed in such numbers that they were salted down. The pellets used for goose hunting were almost the size of a small buckshot, while shot used for grouse and prairie chickens were considerably smaller. I have operated on at least half a score where from one to thirty shots were found in the lumen of the appendix, or they were scooped up from the wound in the rupture cases, of which a few came under my care. Not a single case of leaden pellets in the appendix has occurred in my service during the last twenty-five years.

One of the most virulent cases I can recall was that of a young man who remembered that while riding on top of a load of hay, he accidentally swallowed a straw he was munching. Shortly afterwards it was found in the lumen of an gangrenous appendix. It proved to be part of a so-called "foxtail."

Ordinary common pins were found in three patients.

A medical confrere referred a young man suffering from an acute attack of appendicitis. There was pain and extreme tenderness over McBurney's point and slight typanitis. Temperature and pulse were normal. We decided there was no imemdiate emergency and, therefore, the operation was postponed until the following morning, the patient having been brought in on the evening train. In the morning most of the pain and tenderness had disappeared, and there was no evidence of tympanitis. An incision was made over McBurney's point. The first cut severed the skin only, the scalpel apaprently becoming so dull that it did not sever the fascia. Considerable more pressure was applied on a second and third stroke, which caused something to give away imemdiately beneath the scalpel. It suddenly plunged through the whole thickness of the fascia and the immediate underlying structure without entering the peritoneal cavity. On inspection we found imbedded in the tissue covering the fascia a small sized darning needle, which in its migration had caused the pain and tenderness that had been mistaken for an acute attack of appendicitis. Both pieces of the broken needle were removed, the abdominal cavity was entered, and a large and slightly inflammed appendix was removed.

In the last and most interesting case of this series, we found a two and a half inch twig from a high-bush cranberry loose in the abdominal cavity, from a perforation in the appendix. The patient, a doctor, while hunting in the neighboor of Grand Rapids, Minnesota, became so excited at the sight of a deer that he swallowed the twig which he had in his mouth at the onset of the buck fever. He did not give the swallowed object the slightest attention until a week or two following when he was attacked with severe griping in the lower right abdomen. He realized that he had an attack of appendicitis and immediately took the train for Grand Forks, where I operated on him an hour or so after his arrival. We found a perforation in the appendix, but otherwise the organ did not show any marked evidence of inflammation. There was marked inflammation, however, in the surrounding structure, but we were about to close the incision when I unexpectedly found the long twig in a fold behind the cecum. The doctor made a rapid and uninterrupted recovery.

To these cases may be added one where a large toothpick was the offending foreign body. A farmer living

(Continued on Page 612)

PRESIDENT'S LETTER

THOSE engaged in the pratice of medicine would like to know all there is to know about medicine, but for several generations this has been impossible; thus, many physicians are being forced to restrict their practice to certain fields in order that they may bring to their patients the benefits of advanced knowledge. Specialization in medicine has been the target for much criticism, and the specialist has been humorously defined as one who knows more and more about less and less.

Progress will not be denied. The Victorian philosopher, Herbert Spencer, in attempting to define the law of progress, said that it was but another name for increased specialization. Decry, as we will, the increased specialization in medicine—today, we must accept it as progress, and lament though we may, the passing of the good old days when the family physician was supposed to know all things, they will never return. He knew, only too well, the limitations of his knowledge. The modern family physician is one of the most useful of the specialists.

One may well wonder how far limitation of practice in the varied fields of medicine can go, for there seems no end to its growth. The ultimate controlling force will be an economic one, for when the number of specialties becomes too great an expense for the public to bear, they will be carried only so far as they can be paid for. Specialization, properly conceived and carried out, is humanitarian and a blessing, but when developed on a basis of inadequate and poor training, with subsequent laziness and indifference to progress in the field, and when used chiefly for the selfish interests of the specialist himself, it is an evil. The man who is to specialize in any of the many fields of medicine should have a sound educational background and a training that will fit him for the acquiring of new knowledge in his chosen field. He should have the mental faculties for adding to his learning the elusive wisdom. But above all, he should have that indefinable something called character, which will enable him to withstand the temptations that lead to the exploitation of his patients. With these qualifications fulfilled, we may be certain that the public will be better served.

It is difficult not only for the public, but for the profession at large, to know which men holding themselves out as specialists are properly qualified. Realizing this, the various specialties, through their organized societies, are attempting to establish some channels that will let the profession know which physicians have served the necessary apprenticeship, and can safely be entrusted with the care of patients needing special diagnostic investigation and treatment founded thereon. It is difficult to start such a roster, but once established, young physicians will be eager to have their names on it, and will be required to pass examinations and tests that will indicate their worthiness. It seems better to keep this work independent of state control.

Thus far, the education of the specialist has been a postgraduate affair and it would seem best to keep it so. However, in certain of the broader specialties it may be wise for the student to direct his undergraduate studies in the direction of his chosen field.

The medical profession of Great Britain has been more reluctant even than our own to recognize the advance of the specialties, but a recent article by Sir Humphrey Rolleston* on "The changes in the medical profession and advances in medicine during the last fifty years" points out that whereas in 1882, in the long established and well-known medical quarter of Harley and Wimpole Streets, in London, there were 116 specialists; today there are 1,125. During this period the medical population of Great Britain and London has about doubled, whereas the specialists have increased ten-fold.

Knowledge will increase and no doubt with it will grow the number of specialties, but augmentation must be governed by the common sense of the profession, and if that is not sufficient, ultimately by economic factors.

W. A. Henderson.

President,
Minnesota State Medical Association.

*Rolleston, Humphrey: The changes in the medical profession and advances in medicine during the last fifty years. Brit. Med. Jour., 2:129-134 (July 23), 1932.

EDITORIAL

MINNESOTA MEDICINE

Official Journal Minnesota State Medical Association, Southern Minnesota Medical Association, Northern Minnesota Medical Association, Minnesota Academy of Medicine, and Minneapolis Surgical Society.

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THE NATIONAL ECONOMY LEAGUE

In an editorial entitled "Unwarranted Veteran Expenditure," which appeared in this journal in June, the opinion was ventured that the drain imposed on the Federal Treasury by unjustified demands on the part of the World War veterans had reached such a point that it would be well for truly patriotic veterans to form another organization independent of the Legion to save the government from financial ruin. This is just what was done in May of this year by a group of veterans "largely of the old Plattsburg crowd to whom it was apparent that the largest single economy that could be made in the national budget, without affecting any operating activity of the government, was the elimination of certain unjustifiable appropriations now in the law in the interest of veterans who suffered no disability in the war" as related by General Harbord at another meeting held in New York City, July 26, for the further organization of the National Economy League.

Our War Congress in 1917, in an effort to avoid some of the pitfalls and scandals formerly associated with the pension system, passed some very wise legislation.* Provision was also made for life insurance up to $10,000 for each soldier at a rate he could handle with his service pay. The additional cost of the insurance issued at war time with a peace-time rate was borne by the government and this has already cost the government more than a billion dollars. Provision was also made for disability compensation on a percentage basis, as a result of which thousands of veterans, widows, children, and parents are receiving checks ranging from $8.00 to $250.00 a month. Vocational training was also supplied the veterans at a total cost of 645 millions of dollars (incidentally at an average cost of $5,000 for each graduate).

All this was right and proper, but legislation for the veterans should have stopped here with provision made for those who suffered as a result of war disabilities. As happened following other wars, however, an active minority in the veterans' organization began bringing pressure to obtain further privileges. Highly paid and clever lobbyists representing an organized minority of some 10 per cent of the voters have forced through Congress a series of bills which have virtually made of veterans a privileged class.

First came, in 1924, the Bonus or Adjusted Compensation, a term coined better to signify an inferred justice. This was roughly a dollar a day additional pay with a maximum of $500 (a dollar and a quarter a day for overseas duty, with a maximum of $625) virtually in the form of an endowment life insurance policy payable with compound interest in 1945.

It was also in 1924 that free hospitalization and certain accompanying compensation was extended to veterans for all disabilities irrespective

*With more than four million men called into service the possible cost from a repetition of the pension system in this war was only too evident. The last pension for a widow of a soldier in the Revolutionary War was paid in 1910. The burden of pensions has invariably been handed down to several succeeding generations. While there were fifty-three million dollars paid in 233,000 pensions fifteen years after the Civil War, some 163 millions were paid in 862,000 pensions forty years after the war.

of whether they were the result of service. Thus, if two men hit by an automobile while crossing a street sustain injuries, the one, a veteran, receives hospital and medical care and compensation at government expense; the other, too young perhaps to have been drafted during the war, pays his own costs and is taxed to help pay for his veteran companion.

In 1928 the Emergency Officers Law was passed. As a result several hundred individuals now in civilian life who were emergency officers in the World War are now drawing retirement pay on the same basis as a regular army officer, in addition to their regular disability compensation.

The allowance in 1931 of a loan of 50 per cent of the Bonus and the attempt to intimidate Congress this year into granting the remaining 50 per cent on the 1945 valuation is all too recent history to require coment.

The passage, by the House, of the Rankin Bill is the last straw. This provides for a monthly pension of $20 a month for every veteran's widow. If this bill becomes law one can scarcely conceive of the load that taxpayers will have to carry during the next fifty years. It is estimated by Charles M. Mills that by 1966 we will be paying $3,800,000,000 a year to the veterans if present legislation is allowed to continue.

And what has been the result of this additional legislation? Last year more than 12 per cent of the national budget was spent on veterans. If the Bonus payment in 1931 is added, practically one billion of the four billion dollar federal budget went last year to the veterans. Some six billion have already been spent on the veterans. If the present laws continue unchanged the veterans by 1945 will have cost the taxpayers of the country twenty-one billions or as much as our share of the cost of the war. As some one has stated, it might have been cheaper if Germany had won the war.

Our prodigious expenditures become the more apparent by comparison with England. Total expenditures on veterans by England decreased in 1931 some 53 per cent over 1921, while they showed an increase of 29 per cent in the United States. The number of patients in government hospitals in England showed a decrease of 96.8 per cent in 1931 compared to 1920, while in the United States there was an increase of 100 per cent in the same period. This is the result of England's adhering to a policy of paying benefits only for disabilities due to service.

The seriousness of the financial situation of federal and state government in our country is becoming more and more evident. With total federal and state indebtedness at the enormous figure of thirty billions of dollars (seven times the 1913 figure), an estimated deficit of three billions in this year's federal budget, 28.9 per cent of the federal budget necessary to pay the interest on the national debt, taxes already in many instances confiscatory, serious minded citizens may well be concerned.

What has been the attitude of the medical profession? Following the extension of free hospital facilities for non-service disabilities in 1924, state and national medical organizations passed resolutions in protest of the injustice to private hospitals, the medical profession and the taxpayers in general. Our protests were in vain. Some thought us selfish. An extensive hospital building program was begun to care for the non-service free cases which began to increase until last year they outnumbered the legitimate service-connected cases. As a compromise, the medical profession proposed the Shoulders plan to utilize already existing private hospitals and save the government the cost of further veteran hospital construction. It was felt that in emergency cases, particularly, the veteran would obtain better care with less cost. Nothing was said in the plan as to how the physician was to be paid; he as usual was to obtain his fee if he could.

Now it has become evident that the cost of providing the necessary thousands of additional beds for veterans is a comparatively small item in the total amount now being spent and to be spent in the future on the veterans. Since the war, some 450 millions have been spent for medical and hospital care of veterans. This seems like a large amount, but according to revelations being stressed by the National Economy League fully this amount of nearly a half billion dollars is being spent by the government *yearly* for non-service connected disabilities.

The first objective of the National Economy League is to bring pressure to bear to terminate this unjustifiable expenditure by the government at once, and the League should have the unanimous support of the medical profession.

The National Advisory Council of the League is headed by Ex-President Calvin Coolidge and includes the names of Alfred E. Smith, Elihu Root, Newton D. Baker, General John J. Pershing, Admiral William S. Sims, Commander Richard Byrd, with Archibald B. Roosevelt, secretary, and Graham V. Blaine, treasurer. A national executive committee of representatives from all the states is being formed under the chairmanship of Granville Clark. President Hoover has voiced his approval of such a non-partisan organization to oppose extravagance in national, state and municipal governments. It does seem as though an organization to give voice to the majority and give moral support to our week-spined legislators in resisting minority lobbies is needed.

POLIOMYELITIS IN 1932

False rumors of a recurrence of an epidemic of poliomyelitis this year in Minnesota have reached the State Health authorities. There is nothing in the reports of cases so far this year to indicate that the disease will reach anything like epidemic proportions unless the epidemic period is shifted this year from June to a date later than our going to press.

According to the State Department of Health five cases were reported in the state in January with one death following infection in December. In March three cases were reported; in April, one; in June, eight, and in July, fifteen cases. Up to the middle of August seven additional cases have been reported, two of these in Minneapolis and two in Saint Paul.

The profession should, however, always be polio-minded at this time of the year in order to detect particularly the mild cases which can so easily escape recognition.

Poliomyelitis cases and even suspected ones should be reported at once by telephone or telegraph to the Division of Preventable Diseases at the University Campus. The services of the Division are available at all times.

MISCELLANEOUS

SOCIAL INSURANCE UNDERMINES NATIONAL CHARACTER (continued)

EDWARD H. OCHSNER, M.D.
Chicago

Someone has said, "Happy is the nation that has no history." Whoever said this probably had in mind the old type school history textbooks which contained little besides records of military campaigns, revolutions and international wars. Viewed from that standpoint the epigram was unquestionably true. Today a more suitable epigram would be: Happy is the nation that has no need for charitable organizations or devices. The ideal society would be one in which every individual can and does secure a decent living for himself and those dependent upon him by the "sweat of his brow," or by mental exertion, or, what would be better still, by the application of both brain and brawn.

There is no fundamental difference between outright charity and social insurance; both undermine character; both have a tendency to pauperize the citizen, for both rob the individual of his self-reliance and his enthusiasm and his urge for industry; they both penalize the honest, frugal and industrious, and favor the lazy, shiftless and immoral because they inevitably favor the unfair and inequable distribution of the results of labor; both encourage malingering and favor neuroses; both often give something for nothing or much for little, which is the basis of parasitism, and both delay the ultimate goal when every man shall reap the fruits of his labors.

The man who once accepts charity, particularly if it is not a case of dire necessity, is not quite so fine a man as he was before. He has lost something that nothing can replace. War, pestilence, or general disaster may reduce anyone of us to want and penury and then there is no disgrace in accepting aid from our fellowmen; but under ordinary circumstances no able-bodied individual with fair intelligence and health has any moral right to that which he has not honestly earned.

The proponents of Compulsory Health Insurance will undoubtedly say that it was with the view of saving men and women from the stigma of being paupers and the evil effects of pauperism that this and other phases of social insurance were brought forward. Exactly, but what has actually happened they did not foresee. As is so generally the consequence when a law is enacted on an emotional basis instead of on sound reasoning and adequate experience, an element was introduced even worse than pauperism; besides, pauperism was not relieved nor even mitigated.

There are two distinct types of paupers. The mentally and morally subnormal who are not, in any way, injured by the stigma of pauperism and who still remain paupers because no Compulsory Health Insurance law, so far devised, includes or can include them. They are the "unemployables" whom industry cannot use. The second class are old people, who in their youth have been lazy or extravagant, or who have lost their savings through poor investments. Those who have been lazy and extravagant are simply reaping their just reward and have no one to blame but themselves and it is morally wrong for the government to tax the thrifty and industrious for their support except in almshouses. The way to deal with the problem of the investment sharks is to teach the pupils in our high schools something about investment and to hang the gold brick and non-secure security salesman, or if this is too drastic, devise some other way of putting them out of business.

Compulsory Health Insurance has simply added parasitism to pauperism. The effect upon the insured and upon the public in general is almost as bad as it is on the medical profession. It encourages malingering and deception; it puts a premium on sloth and shiftlessness and a penalty on industry and integrity and thrift; it robs industry of its just reward; and it encourages parasitism.

One of the first effects observed after its introduction in Germany was the changed attitude of a large group of the insured. Before the law went into effect, patients came to their physicians for the relief of real ailments; after it went into effect an ever-increasing number came with imaginary and simulated ailments for the purpose of getting the sick benefit or free hospital care. The latter was particularly the case in the fall of the year when many came complaining of things that were difficult to diagnose and hence difficult to exclude, such as spinal concussion, neuritis, and vague abdominal pains. As time has passed this abuse has gradually grown to appalling proportions as the following statistics indicate. Dr. Potts, of Oak Park, cites the following:

In a check-up in Brawnschweig, two thousand eight (2,008) people on the sick list were asked to report for a check-up examination. This induced eight hundred sixteen (816) to report for work at once, two hundred eighty-nine (289) were found fit for work and only nine hundred three (903) or less than forty-five (45) per cent of those receiving sick money were actually sick. The proponents of Compulsory Health Insurance will undoubtedly say this is an individual instance. But not so. This abuse is so almost universal that it is seriously affecting the general honesty of the rank and file of the citizens of those countries where it has been in operation the longest. Social insurance is one of the major factors which has brought Germany to the very verge of economic ruin, and worse even than that—it is undermining the fundamental honesty and moral integrity of the German citizen.

A FORUM OF THE COMMITTEE ON PUBLIC HEALTH EDUCATION

No More Discounts

What is the Minnesota Benefit Association?

Very few physicians knew what it was until someone chanced upon the bulletin published by the executive secretary of the organization in which appeared a directory of commercial and professional organizations or persons who would give a discount to association members.

Investigation showed that this was a legitimate and efficient association of city, county and village employes organized to provide disability insurance for its members; that, as such, physicians could have no possible quarrel with it. Actually, the doctor stands to profit by such organizations, as by any system of insurance, which provides funds in time of need to pay for professional services.

The matter of the directory to which a committee of the State Association took exception, in so far as it applied to physicians and surgeons or to clinics, brought committees of both organizations together to talk things over. The result of this discussion was entirely satisfactory to the doctors as the following resolution passed by the Board of Directors of the Benefit Association will show:

"Motion made and carried that we comply with the request of the committee from the Minnesota State Medical Association and exclude from the Minnesota Bulletin any advertising relative to physicians, surgeons or medical clinics. Also that we refrain from sending out any circulars or notices stating that there would be any discount with physicians or surgeons."

The Minnesota Benefit Association is to be distinguished sharply from the various abortive group coöperative services which appear from time to time. These attempt to supply from their own organization the necessary professional services to their beneficiaries. In spite of occasionally formidable backing they do not survive.

County Society Clinics

When Dr. John R. Neal, President of the Illinois State Medical Society, talks about public health education he merits an interested audience. Dr. Neal himself and the Illinois society have been in the vanguard of the movement in organized medicine to play a leading rôle in public health education. In a talk given before the Illinois Tuberculosis Association, recently, he mentioned an Illinois experiment in public health work by a county medical society which should be of interest to county medical societies everywhere; that of the semi-annual orthopedic clinic conducted by the Warren County Medical Society of that state:

"The very successful conduct of a clinic for crippled children in Warren county stands out as a perfect example of coöperation among three independent groups in promoting the finest type of health education. Lay organizations raise the money for the clinic. They give their time to seeing that children are transported to the place of the clinic. The health department lends its support and coöperation and the physicians bring their patients for examination and consultation. These clinics have been conducted twice a year for the last five years and complete records of progress of each patient are available. This one educational project by a county medical society has greatly benefited the public and it has as a consequence secured for the medical profession intelligent coöperation in the care of handicapped children.

"It is the belief of the organized medical profession in Illinois that for the promotion of education along lines of physical well being for the welfare of children in the community and for raising the standards of public health certain things are needed:

"Better coöperation between official and volunteer agencies.

"Education of the general public which shall stimulate a sense of personal responsibility for health.

"Better facilities for those who have been educated to look for them.

"Better coördinated and more efficient means for the care and treatment of the indigent poor."

OF GENERAL INTEREST

The marriage of Miss Irene Cooney and Dr. J. J. Kolars, both of Le Center, Minnesota, took place July 30, 1932, at St. Michael Church, in Saint Paul.

Dr. W. P. Anderson, formerly of Anoka, has established offices for the practice of medicine in the Buffalo National Bank building at Buffalo, Minnesota.

Dr. and Mrs. Frank T. Cavanor of Minneapolis recently returned from a two months' stay in Europe. Dr. Cavanor is a member of the Eye, Ear, Nose and Throat Staff of the University and devoted part of his time to study in Vienna.

Dr. Alex H. Brown, his daughter Mary and niece, Miss Alice Hill, all of Pipestone, Minnesota, returned August 13 from a motor trip to Canada. They visited in Ottawa, Ashawa and Cornwall, Ont., besides other interesting points. Cornwall, Ont., is Dr. Brown's old home. Their trip into Canada and return was by way of Sault Ste. Marie.

Dr. C. N. Spratt of Minneapolis recently returned from Denver, where he lectured on "Foreign Bodies" before the Colorado Congress of Ophthalmologists and showed a three-reel film of his method of operation on cataract and glaucoma. Dr. Spratt also appeared before the Pacific Coast Ophthalmological Society at Seattle, Washington, where he showed the same film.

The Aid Association of the Philadelphia County Medical Society, organized in 1878 to furnish financial assistance for needy members, is establishing a perpetual fund in honor of Dr. John V. Deaver, the income of which is to be used to aid needy physicians or their families wherever located. Those who wish to make contribution to this worthy cause may send a check payable to the Aid Association of the Philadelphia County Medical Society addressed to the Secretary, Dr. Francis H. Adler, 313 South 13th Street, Philadelphia.

BASIC SCIENCE BOARD

NATUROPATHIC BLANKET SELLER CONVICTED

State of Minnesota *vs.* Carrigan

On July 19, 1932, James J. Carrigan, 2143 Dayton Ave., St. Paul, Minnesota, entered a plea of guilty to a charge of practicing healing without a Basic Science Certificate before the Honorable Gustavus Loevinger, Judge of the District Court.

The defendant, who claims to be a chiropractor and a naturopath, and who formerly practiced in Alberta, Canada, attempted to treat one Josephine Shanoha, 446 Goodrich Ave., St. Paul, who is afflicted with a mental and nervous disorder. In addition to giving the patient some massage treatments, defendant sold her a magna-coil electric blanket for $100.00, and rupture appliance for $12.00. The defendant has no medical education whatsoever and upon being questioned by the Court stated that he left school at the age of sixteen. The Court sentenced Carrigan to ninety days in the St. Paul Workhouse, which sentence was stayed for one year and the defendant placed on probation, conditioned that he absolutely refrain from practicing healing and from selling any devices or remedies for the curing of ailments. The Court also required the defendant to return the $12.00 received from the sale of the rupture appliance for the reason that the rupture appliance had been returned to the defendant.

Through the courtesy of the Minnesota State Board of Medical Examiners, the remarks of Judge Loevinger in sentencing the defendant are quoted:

(By Judge Loevinger) "I am mindful of the fact that one of the easiest methods of imposing upon a gullible public is to take advantage of the pain and suffering and anxiety which a person having some ailment or deformity or affliction has, and to prescribe a remedy of one kind or another. The more mysterious and the more involved the remedy is, the easier it is to get some people to accept the promise of the persons who are selling such articles or such treatments. Sometimes I think that more money is spent by the American public on worthless nostrums of one kind or another sold under pseudo-scientific explanation as to their curative value than probably for any other one thing. The least that the Court can do is to protect the public, according to law, from persons who are preying upon the ignorant and the gullible, who are subject to being deluded by such fraudulent and illusory promises. This is obviously not a case where one neighbor goes to another neighbor and tells him his own experience, to induce his neighbor to also try the same thing. We are all subject to being advised by our friends on all sorts of cures they have tried out and are alleged to have worked. In this case we are obviously dealing with a commercial enterprise in which this defendant was attempting to profit. It was not simply a case of a personal friend going to a personal friend and offering to give friendly advice. That is why the defendant is here in court and that is why the court is required to sentence him to punishment."

The remarks of Judge Loevinger clearly indicate that quacks and swindlers will have rough going when arraigned before him. The usual good coöperation was received from M. F. Kinkead, County Attorney and his staff.

CHIROPRACTOR SENTENCED TO COUNTY JAIL

State of Minnesota *vs.* Sjoden

On July 23, 1932, George Sjoden, thirty-eight years of age, a chiropractor residing at Kensington, Minnesota, entered a plea of guilty to practicing medicine without a license before the Hon. John A. Roeser, Judge of the District Court at St. Cloud.

The defendant had agreed to cure a case of eczema for a fee of $20.00. The medicine was to be obtained in Chicago and the patient was promised immediate relief.

Sjoden has previously been convicted of practicing medicine without a license and also admitted to the Court that he had been arrested on two previous occasions for writing checks without sufficient funds. Sjoden admitted that he had been in other difficulties at Mora, Princeton and Motley, Minnesota.

The defendant informed the Court that he is suffering from a severe case of asthma and stated that he would like to go to a different climate. Judge Roeser sentenced Sjoden to eight months in the Douglas county jail and gave him until August 2, 1932, to decide whether he would improve his health elsewhere. If the defendant is still present in Minnesota after that date he must serve every day of his sentence.

Splendid coöperation was received by the State Board of Medical Examiners from County Attorney Hanson and Sheriff Urness of Douglass County.

"SLEEP INDUCING" CLAIMS FOR SPECIFIC FOODS

The Committee on Foods reports that "sleep inducing" claims are not permissible for specific food beverages because of their misleading character. (Jour. A. M. A., May 7, 1932, p. 1655.)

OBITUARY

Dr. James Walter Andrist

James Walter Andrist, formerly of Owatonna, died May 21, 1932, of cardiorenal disease at San Diego, Cal. Dr. Andrist was fifty-seven years old. He was a member of the Steele County Medical Society, the Minnesota State Medical Association and the American College of Surgeons. He graduated from Rush Medical College in 1900.

Dr. Amos L. Baker

1852-1932

Word has been received of the death of Dr. Amos L. Baker of Kasson, which occurred July 20, after a prolonged illness from cardio-renal disease.

Dr. Baker was born at New Sharon, Maine, December 6, 1852. He was graduated from Rush Medical College in 1887, and was married to Miss Lulu Atwood of Monroe, Maine, in February of that year. He came to Minnesota to practice his profession, locating finally at Byron, where he lived until 1900, when he located at Kasson in Dodge County. He continued an active and extensive practice at Kasson until obliged to retire in 1926 because of failing health. He was formerly a member of the Dodge County Medical Society and Minnesota State Medical Association.

Dr. Baker is survived by his widow and two daughters, Mrs. Ethel Odden at Benson, Minnesota, and Mrs. Vera Tice of Huron, South Dakota.

REPORTS AND ANNOUNCEMENTS OF SOCIETIES

MEDICAL BROADCAST FOR THE MONTH

The Minnesota State Medical Association Morning Health Service

The Minnesota State Medical Association broadcasts weekly at 11:15 o'clock every Wednesday morning over Station WCCO, Minneapolis and Saint Paul (810 kilocycles or 370.2 meters).

Speaker: William A. O'Brien, M.D., Associate Professor of Pathology and Preventive Medicine, Medical School, University of Minnesota.

The program for the month of September will be as follows:

September 7—Rheumatic Fever
September 14—Baby Teeth
September 21—Problem of Drug Addiction
September 28—Tumors of the Bladder

MEDICAL RESERVE COURSE

The medico-military course of inactive duty training for Medical Department Reserve officers, which has been held at the Mayo Clinic during the past three years, will again be held this year from October 16 to 29, both dates inclusive. This inactive duty training will follow the plan so well worked out under the auspices of Colonel George A. Skinner and the military features will be under his personal supervision.

This medico-military course is based on the sound principle that when the Reserve officer gives up two weeks of his time for inactive duty training at his own expense he shold derive some benefit therefrom which will definitely help him in his profession. This method of training takes cognizance in a high degree of this principle in that the student officer gets two weeks of excellent clinical post-graduate work without fee and without any greater loss of time from his practice than normally is incurred for post-graduate work, along professional lines. At the same time he gets a definite amount of medico-military training, the benefits of which he retains.

In furtherance of this concept, the Mayo Clinic has freely placed all of its clinical material, laboratory, museum, library, and so forth at the disposal of the Medical Department Reserve officers taking this inactive duty training. The faculty and staff of the Mayo Clinic have volunteered to give their services free in the interests of national defense.

This short course is equally applicable to general practitioners and specialists. The morning hours are devoted to purely professional subjects selected by the student officers. The afternoon hours pertain solely to medico-military subjects and the evening hours are covered in a lyceum course of general interest.

Application for this course of inactive duty training should be made either to the Director of the Mayo Foundation, Rochester, Minnesota, or to the Corps Area Surgeon, Seventh Corps Area, Omaha, Nebraska. Applications should state the character of the work the candidate desires to follow in the morning hours. All student officers are expected to attend and to participate in the afternoon and evening sessions. Each applicant should fully understand that the invitation to accept this course of study without charge is extended by the Mayo Clinic; that the project is without expense to the Government; and that two hundred hours' credit will be given to those who take and complete the course.

INTER-STATE POST GRADUATE ASSEMBLY

The annual International Assembly of the Inter-State Post Graduate Medical Association of North America will be held in the Murat Theater and Shrine Temple, Indianapolis, Indiana, October 24 to 28, 1932.

Many distinguished teachers and clinicians of Canada and the United States appear on the preliminary program. Sessions consisting of clinics and addresses will occupy morning, afternoon and evening for the five days, with a banquet on Friday evening.

McLEOD COUNTY SOCIETY

O. W. Scholpp of Hutchinson was elected president and W. W. Klima, secretary and treasurer of the McLeod County Medical Society at the societies' annual meeting, June 29.

MINNESOTA MEDICAL ALUMNI ASSOCIATION

The Minnesota Medical Alumni Association, following a precedent established three years ago, will hold their annual business meeting and medical program on Friday, October 28, 1932, in the Eustis Amphitheater at the University Hospital. This will precede the regular home coming day and football game scheduled for October 29 at the University.

The morning session will be devoted to the surgical specialties. There will be a lunch and business meeting at noon. Internal medicine, pediatrics and X-ray subjects will be discussed in the afternoon. The complete program will appear in the October number.

Not only Minnesota alumni, but all medical practitioners interested, are requested to attend this meeting.

SOUTHERN MINNESOTA MEDICAL ASSOCIATION

Fortieth Annual Meeting
September 12, 1932—Rochester, Minnesota

The officers of the Southern Minnesota Medical Association are: Dr. C. C. Allen, Austin, president; Dr. R. V. Williams, Rushford, first vice president; Dr. B. J. Gallagher, Waseca, second vice president; Dr. M. C. Piper, Rochester, secretary-treasurer. Dr. H. C. Habein, Rochester, is chairman of the Program Committee and Dr. S. F. Haines, Rochester, is chairman of the Committee on Local Arrangements.

Registration for members will take place in the Kahler Hotel lobby at 8 A. M., Monday, September 12, 1932. The scientific program will consist of clinics in the various specialties by various members of the Mayo Clinic staff in the different hospitals in the morning. A luncheon and business session will be held in the Kahler Hotel dining hall at 12:12 P. M. In the evening a banquet will be held at the Rochester Country Club to be followed by an informal dance. Bridge and a golf tournament will be provided in the afternoon for visiting ladies.

The following addresses will constitute the afternoon program to be held in Plummer Hall, in the Clinic Building:

1. Convulsions in adults, from a neurologic standpoint.
   Dr. E. M. Hammes, St. Paul.
2. Practical diets in the treatment of diabetes.
   Dr. A. H. Beard, Minneapolis.
3. Case of pneumothorax.
   Dr. R. V. Williams, Rushford.
   Discussion: Dr. S. W. Harrington, Rochester.
4. Bronchoscopic problems in general practice.
   Dr. V. J. Schwartz, Minneapolis
5. Case Report: Mediastinal abscess.
   Dr. H. J. Lloyd, Mankato
6. Treatment of congestive heart failure.
   Dr. H. W. Rathe, Waverly, Iowa
7. Pitfalls in the diagnosis of renal tumors.
   Dr. T. H. Sweetser, Minneapolis
8. Case Report: Hyperparathyroidism.
   Dr. J. L. Tavenner, Waseca
   Discussion: Dr. R. M. Wilder, Rochester
9. Ryerson operation for soft corns.
   Dr. E. S. Geist, Minneapolis
10. Case Report: Chronic anemia with splenomegaly and pseudo-agranulocytosis.
    Dr. P. A. Lommen, Austin
11. Modern methods of caring for the hard of hearing.
    Dr. Horace Newhart, Minneapolis
12. Further report on case of hypertension.
    Dr. C. Koenigsberger, Mankato

NORTHERN MINNESOTA MEDICAL ASSOCIATION

Monday and Tuesday, September 19 and 20, 1932
Crookston, Minnesota

1. "Surgical Clinic"—Dr. Owen Wangensteen, University of Minnesota, Minneapolis.
2. "Medical Clinic"—Dr. Moses Barron, Minneapolis, Minn.
3. "Pediatric Clinic"—Dr. Ralph Pray, Fargo, N. Dak.
4. X-ray Demonstration—Dr. Leo Rigler, University of Minnesota.
5. Papers will be presented by the following:
   Drs. J. M. Hayes, V. J. Schwartz, Hobart Reiman and J. K. Anderson, Minneapolis.
   Drs. J. R. Manley, C. M. Smith and F J. Hirschboeck, Duluth.
   Drs. Waltman Walters or D. J. Balfour, and Dr. Russell Wilder or Dr. C. H. Watkins, Rochester.
   Dr. O. J. Hagen, Moorhead.
   Dr. S. Sturmans, Erskine.

Dr. D. Stewart of Nanette, Minn., has also been invited.

Ex-Governor, Theodore Christianson will speak at the banquet Monday evening on "An Answer to Pessimism."

Dr. O. M. Oppegaard is in charge of the local arrangements.

The officers of the Society are: President, Dr. George Wattam, Warren; vice president, Dr. C. M. Smith, Duluth; Secretary and Treasurer, Dr. C. J. Larson, Detroit Lakes.

WOMEN'S AUXILIARY

Minnesota State Medical Association

President—Mrs. Edward Schons, Saint Paul
Chairman Press and Publicity—Mrs. Glen R. Matchan, Minneapolis
Editor—Mrs. Horatio B. Sweetser, Jr., Minneapolis

The annual meeting of the Women's Auxiliary of the Minnesota State Medical Society was held in the St. Paul Auditorium on May 24 and 25, with Mrs. James Blake presiding. An Executive Board meeting with luncheon at the Women's City Club constituted the program for the first day. On May 25 an open meeting and the election of officers took place. This was followed by the Annual Luncheon in the Palm Room of the St. Paul Hotel. At this time, Mrs. James Blake, State President, introduced the following officers for the coming year: President, Mrs. Edward Schons, St. Paul; president-elect, Mrs. A. A. Passer, Olivia; recording secretary, Mrs. Werner Hemstead, St. Cloud; treasurer, Mrs. W. A. Coventry, Duluth; auditor, Mrs. B. R. Karn, Ortonville; first vice president, Mrs. A. M. Hanson, Faribault; second vice president, Mrs. A. E. Sohmer, Mankato; third vice president, Mrs. O. E. Locken, Crookston.

We are proud to announce that at the National Auxiliary meeting in New Orleans in May, our past state president, Mrs. James Blake, was made president-elect of the National Medical Auxiliary.

LAURA R. BAXTER (MRS. S. H.).

PROGRESS

Eye, Ear, Nose and Throat

SHARE OF CRYSTALLINE LENS IN OCULAR REFRACTION: Edward Jackson, M.D., Denver, Colo. (Trans. Amer. Acad. of Ophthal. and Otolaryng., 1931, p. 66). Since Young, 100 years ago, showed that the lens changed its shape with accommodation, little light has been thrown on the share of the lens in the static refraction of the eye.

It is impossible to get an accurate mathematical measurement of the refraction of the lens because of the continual growth of the lens and the formation of the fixed nucleus with a fixed refraction index. The only true measurement is obtained by determining the total refraction of the eye and subtracting the corneal refraction as obtained by the ophthalmometer. In the case of the latter, there are errors of 0.25D to 0.50D, depending on the operator's skill and the repose of the patient. In a study of 644 eyes, the spherical corneal refraction had not changed more than 1D in 626 eyes. Of 22 eyes in which there was a change of more than 1D, 12 showed an increase and 10 a decrease. The average age where an increase occurred was 32 while it was 41 where a decrease occurred.

The author assumes an increase of spherical corneal refraction in early life. There was a change of 1D. or more of corneal astigmatism in 44 eyes, mostly in young people. Only 3 cases over 50 showed such a change.

The greater mass of total refraction changes occurs after the age of 50. Of 76 such cases examined three to five times, there was no certain or material change in the corneal refraction but each required a number of changes of the total refraction, the average number of changes being 4.24 and the average time between changes being 4.0 years.

From these studies, in all the cases (644) except 22, the change of the total refraction was due to that of the crystalline lens. These changes occur at all periods of life. This series shows the practical importance of the crystalline lens in refraction of the eye.

FRANK W. STEVENSON.

PEDIATRICS

THE INCIDENCE OF RESPIRATORY INFECTIONS DURING THE FIRST FIVE YEARS OF LIFE: C. C. McLean, M.D., Birmingham, Alabama (Arch. Ped., Vol. XLIX, No. 5, May, 1932). The incidence of respiratory infections during the first five years of life should be of interest to the pediatrician as it comprises approximately 80 per cent of the acute illnesses in children of this age group.

An intensive study of 1,408 respiratory infections seen in 156 children is made in an endeavor to find evidence of a periodic recurrent disease. A small number of children are reported rather than a large group, so as to include only patients with whom they have been in intimate contact and feel reasonably sure were seen in practically all illnesses.

A comparison of the average number of respiratory infections per patient and the average number of months per each respiratory infection in the children with various groupings of the same age and length of observation, shows a marked consistency.

During an exact period of four years from the date of birth in 86 and 70 children, 692 and 563 respiratory infections were seen. The average number of days between infections in the two series were 181.4 and 181.5 days. The average number of respiratory infections per patient in each series was 8.04 infections. The per cent of mild and severe infections in the two series was the same, 41 per cent mild and 59 per cent severe.

Eight hundred forty-five respiratory infections were seen in 86 children observed for an exact period of five years from date of birth. The children were placed in two groups of 43 patients, one group having 416 infections, the other 429, a difference of 13 infections.

In 70 children observed for an exact period of four years from date of birth, 563 respiratory infections were seen. The patients were placed in two groups of 35 children, one group having 285 infections and the other 278, a difference of seven infections.

In 140 children observed for an exact period of four years from date of birth, 1,125 respiratory infections were seen. When the patients were placed in two groups of 70 children, one group had 563 infections and the other 562, a difference of one infection.

The monthly seasonal incidence of occurrences in 845 respiratory infections seen in 86 children observed for an exact period of five years from date of birth, compared with 563 respiratory infections seen in 70 children over an exact period of four years from date of birth, shows a marked consistency.

The removal of tonsils and adenoids apparently had little effect on either the number or severity of respiratory infections.

R. N. ANDREWS, M.D.

PSYCHIC ENURESIS IN NORMAL CHILDREN—AN EXPERIMENTAL STUDY: J. M. Lewis, M.D., and J. Ostroff, M.D., New York (Amer. Jour. Dis. Children, June, 1932, Vol. 43, No. 6). It would seem superfluous to stress the importance of psychic factors in the causation of enuresis in children. Enuresis has been and is an important problem, a fact that was brought out strikingly at the beginning of the study when the authors were able to find only eight children among forty, from 3 to 4 years of age, who did not wet themselves by day or by night. Four of the children were transferred from the main building to one of the small buildings, which is divided into fourteen individual glass cubicles, and were confined to their cubicles during the twenty-four hour period for an entire week. Within twenty-four hours after transfer to the small cubicles, enuresis developed in all these children, not only nocturnally but diurnally. As was to be expected, the children remained continent when transferred to their original wards.

The authors believe that enuresis was induced in these children by the psychic effect of a strange and new environment, and that in some children psychic adjustment took place within forty-eight hours. This interpretation is borne out by the fact that when the change in surroundings was not marked, as, for example, when they were transferred to a similar ward, incontinence did not result, and that if the change in environment had been previously made a second transfer resulted in a less degree of incontinence.

In this connection, the authors would like to call attention to the development of enuresis in some children when they were transferred to private homes. It has likewise been their experience that the development of enuresis in these children was of temporary nature, and they ascribed it to change of environment.

Enuresis must be regarded as a disorder that can be induced at will in some normal children and is thus open to experimental investigation. Psychic enuresis can, therefore, be induced and controlled experimentally, which renders it possible to study various etiologic and therapeutic factors that are commonly associated with this condition.

R. N. ANDREWS, M.D.

(Continued from Page 603)

in the neighborhood of Petersburg had for two or three years suffered from obstinate digestive disturbances. He had consulted a number of physicians, most of whom had diagnosed ulcer of the lesser curvature of the stomach or the duodenal cap. Finally he came under my observation and my diagnosis was that the cause of the ailment was an obstruction in the pyloric opening in the stomach. At my suggestion he submitted to an exploratory operation. We found the first part of the duodenum in a state of chronic inflammation with dense infiltration and masses of granulation tissue superimposed on the structure. The appearance was that of an advanced stage of carcinoma. While attempting to excise sufficient tissue for a biopsy, a hard object was suddenly encountered deep in the mass. Further search revealed that it was of considerable length. One end was isolated and the foreign body carefully extracted. It proved to be a piece of wood three and a half inches long, round, sharp pointed at both ends—an old-fashioned wooden toothpick. One end had penetrated the upper aspect of the pyloric end of the stomach, had entered the lumen of the duodenum, due to its upward turn, and the points had made an exit through the lumen of the gut, transfixing it in its journey from the stomach. The patient made a rapid and uneventful recovery only to be attacked by appendicitis a year later.

LIST OF PHYSICIANS LICENSED BY THE MINNESOTA STATE BOARD OF MEDICAL EXAMINERS JUNE 30, 1932

BY EXAMINATION
(June)

NAME	SCHOOL OF GRADUATION	ADDRESS
Beecham, Clayton Tremain	U. of Minn., M.B., 1932	University Hospital, Minneapolis, Minn.
Bolender, Harold Leland	U. of Iowa, M.D., 1930	929 Selby Ave., St. Paul, Minn.
Bouquet, Bertram Jacob	Washington U., M.D., 1931	Caledonia, Minn.
Buckley, Clarence Harold	U. of Minn., M.B., 1932	Eitel Hospital, Minneapolis, Minn.
Bunker, Bevan William	U. of Minn., M.B., 1932	Rothsay, Minn.
Corwin, Warren Coons	Johns Hopkins, M.D., 1932	1625 W. 25th St., Minneapolis, Minn.
Fitzgerald, Edward Michael	U. of Minn., M.B., 1931; M.D., 1932	525 11th Ave. S. E., Minneapolis, Minn.
Foster, Robert Francis	Northwestern, M.B., 1929; M.D., 1930	603 1st St. S. W., Rochester, Minn.
Gilpin, Sherman Fulmer, Jr.	U. of Pa., M.D., 1929	Mayo Clinic, Rochester, Minn.
Grand, Clifford August	U. of Minn., M.B., 1931	St. Lukes Hospital, Duluth, Minn.
Haven, Walter Kirkland	U. of Minn., M.B., 1931; M.D., 1932	151 Malcolm Ave. S. E., Minneapolis, Minn.
Henry, Clarence John	U. of Minn., M.B., 1932	Foley, Minn.
Hill, Elmer Morris	U. of Minn., M.B., 1931	General Hospital, Minneapolis, Minn.
Hoffman, Malcolm Edwin	U. of Minn., M.B., 1930; M.D., 1932	588 Portland Ave., St. Paul, Minn.
Hospodarsky, Leonard John	U. of Iowa, M.D., 1931	New Prague, Minn.
Hoyer, Ludolf Julius	U. of Minn., M.B., 1932	2308 Logan Ave. N., Minneapolis
Ivers, George Urben	Rush Med. Col., M.D., 1932	Christine, N. Dak.
Johnson, Raymond Gregor	U. of Minn., M.B., 1931; M.D., 1932	123 7th St., Cloquet, Minn.
Kass, Isadore Harris	U. of Mich., M.D., 1929	St. Mary's Hospital, Rochester, Minn.
Knutson, Gerald Arthur	Northwestern, M.B., 1931; M.D., 1932	Buxton, N. Dak.
Kroning, Carl Gustav	U. of Minn., M.B., 1932	St. Mary's Hospital, Duluth, Minn.
Marble, Willard Pearl	U. of Iowa, M.D., 1929	1238 Second St. N. W., Rochester, Minn.
Nelson, O. L. Norman	U. of Minn., M.B., 1931; M.D., 1932	General Hospital, Minneapolis, Minn.
Rasmussen, Ruth Frances	U. of Minn., M.B., 1931; M.D., 1932	111 4th Ave. N. W., Rochester, Minn.
Ryan, George Harold	U. of Manitoba, M.D., 1929	Mayo Clinic, Rochester, Minn.
Schmidtke, Reinhardt Ludwig	U. of Minn., M.B., 1932	Receiving Hospital, Detroit, Mich.
Schwegler, Raymond Allen	U. of Minn., M.B.,1930; M.D., 1931	329 Union St. S. E., Minneapolis, Minn.
Thomson, James Myron	U. of Minn., M.B., 1931	General Hospital, Minneapolis, Minn.
Thoreson, M. C. Bernice	U. of Minn., M.B., 1931; M.D., 1932	888 Grand Ave., Apt. 304, St. Paul, Minn.
Waligora, Daniel John	U. of Minn., M.B., 1932	St. Mary's Hospital, Minneapolis, Minn.
Walker, Arthur Edgar	Marquette, M.D., 1932	1833 Vermillion Rd., Duluth, Minn.
Watterson, Gerald Treslar	Indiana U., M.D., 1932	St. Luke's Hospital, Duluth, Minn.

BY RECIPROCITY

Bryant, Frank Leytze	Jefferson Med. Col., M.D., 1927	3014 Hennepin Ave., Minneapolis, Minn.
Hand, Orra Robert	Washington U., M.D., 1930	3026 W. Lake St., Minneapolis, Minn.
Jordan, Donald Voorhees	U. of Ill., M.D., 1928	126 Oak Grove St., Minneapolis, Minn.
Murphy, Edward S.	Creighton U., M.D., 1916	University Hospital, Minneapolis, Minn.
Weiss, Leo Heinrich	U. of Tubingen, Germany Scientific Degree Dr. of Med., 1927 U. of Goettingen, Germany, 1924	Le Center, Minn.

RADIUM AS A "PATENT MEDICINE"

The recent newspaper reports of the death of a steel manufacturer and sportsman, due to radium poisoning, caused the public to ask: "Why do the federal authorities permit the indiscriminate sale to the public of dangerous 'patent medicines'? The answer is that the National Food and Drugs Act gives the federal officials no power to stop the sale of dangerous nostrums. If no false statements are made *in or on the trade package* of a medicine that enters into interstate commerce and if the presence and amount of the eleven drugs and their derivatives that are mentioned in the national Act are properly declared on the label, the federal officials have no power to stop the sale of such products. According to newspaper reports, the death of the man was brought about by the continued use of "Radithor," put out by William J. A. Bailey of East Orange, N. J. In 1915 a newspaper reported that William J. A. Bailey had been arrested because of his activities in the promotion of the Carnegie Engineering Corporation. In 1915 the postal authorities issued a fraud order against the Carnegie Engineering Corporation. A few years ago Bailey was president and one of the incorporators of Associated Radium Chemists, Inc., New York City, which put out a line of "patent medicines," including "Arium," described as "radium in tablets." Bailey also was connected with the Thorone Company, which purposed to put out "Radium and Thorium Pharmaceutical Preparations." Then William J. A. Bailey, with one Ward Leathers, traded under the name, American Endocrine Laboratories, putting out the "Radiendocrinator," which sold for $1,000. Then came "Radithor," in the exploitation of which Bailey used the trade style, Bailey Radium Laboratories, Inc., sold in cases of thirty bottles for $30. The preparation was guaranteed to be "harmless in every respect." Bailey's next product seems to have been the "Bioray," supposed to give off "a continuous flow of gamma rays." The next excursion into the field of radioactive nostrums brought forth the "Thoronator," which was described as a "Health Spring for every Home and Office." Now we have the "Adrenoray," an alleged radioactive belt which is to be worn over the adrenals. (Jour. A. M. A., April 16, 1932, p. 1397.)

BOOK REVIEWS

Books listed here become the property of the Ramsey and Hennepin County Medical libraries when reviewed. Members, however, are urged to write reviews of any or every recent book which may be of interest to physicians.

PRINCIPLES OF CHEMISTRY. Joseph H. Roe, Ph.D. 3rd edition. 486 pages. Price $2.50. St. Louis, C. V. Mosby, 1932.

AN INTRODUCTION TO DERMATOLOGY. Richard L. Sutton, Jr., M.D. 565 pages. Illus. Price $5.00. St. Louis, C. V. Mosby, 1932.

INTERNATIONAL MEDICAL ANNUAL. Editors: Carey F. Coombs, M.D., F.R.C.P., and A. Rendle Short, M.D., B.S., B.Sc., F.R.C.S. 658 pages. Illus. Cloth. New York: William Wood and Company, 1932.

GROWTH AND DEVELOPMENT OF THE CHILD: Part III. Nutrition. White House Conference Publication. 532 pages. Price, $4.00. New York: Century Co., 1932.

Of all the investigations instituted by the conference of scientists which President Hoover summoned to study the problems of childhood, none appeals to this reviewer so much as does this volume. Here is included a complete, up-to-the-minute review of all the facts pertaining to the development of children. Without being excessively technical or prolix, the multitude of factors associated with nutrition and metabolism are interestingly presented. A rational survey of the latest facts on the various vitamins, as well as a consideration of the functions served by the various organic and inorganic food elements make this more likely to serve as a text on the subject. Numerous practical considerations, such as of protein and energy requirements; food selections for normal diets; the effects of cooking and preserving processes on various foods; and, particularly, of feeding habits in children, with reference to the vexing problem of anorexia, contribute to the value of this excellent study. This deserves a place in the library of all who are interested in the problems of childhood.

THOMAS MYERS, M.D.

AN EXPERIMENTAL AND CLINICAL STUDY OF PAIN IN THE PLEURA, PERICARDIUM AND PERITONEUM: Joseph A. Capps, M.D. 99 pages, $3.00. New York: Macmillan, 1932.

The value of an intelligent understanding of the subject of pain to the practicing physician cannot be overestimated. Therefore, the appearance of a monograph by one competent to cope with the subject is a timely and welcome one. The experimental methods used by the author in his study of the mechanism of pain in the pleura, pericardium and peritoneum are to be commended, and are important in that they not only confirm clinical observations which are generally accepted, but they also serve to demonstrate more accurately the localization of a lesion which is associated with a particular type of distress.

The separation of the types of pain found in affections of these serous cavities into visceral and referred pain is clearly demonstrated. A particularly valuable finding is the corroboration of Mackenzie's opinion that a dry pericarditis is usually a painless disease, the possible exception being the involvement of that portion of the pericardium which is supplied by the phrenic nerve and which gives a referred pain typical for that nerve.

This monograph is recommended to practicing physicians and medical students, who will, aside from the facts brought out, enjoy the excellent exposition of a sound experimental method.

JOSEPH F. BORG, M.D.

NUTRITION SERVICE IN THE FIELD. CHILD HEALTH CENTERS: A SURVEY. Publication of the White House Conference. 196 pages. Price $2.00. New York: Century Co., 1932.

This study consists of two parts, the first of which is devoted to the problem of malnutrition in children. It is estimated that over six million of our forty-five million children are malnourished. The need of efficient instruction in and regulation of children's diets by trained nutritionists is becoming recognized increasingly, particularly during the present depression. Studies of the procedures followed in many large dispensaries, schools and like institutions, which assist in overcoming malnutrition, are accurately detailed in this volume.

The second part of the book is devoted to a survey of child health centers, such as baby welfare clinics and the like. The value of such clinics in maintaining health in the children of the poor, has been long accepted.

Pediatricians, health officials and social workers will find this volume worth while.

THOMAS MYERS, M.D.

MINNESOTA STATE MEDICAL ASSOCIATION

Seventy-ninth Annual Session

Saint Paul, Minnesota

PROCEEDINGS OF THE HOUSE OF DELEGATES

First Meeting—Monday Morning, May 23, 1932

The opening session of the House of Delegates of the Seventy-Ninth Annual Session of the Minnesota State Medical Association, held May 23-25, 1932, at St. Paul, Minnesota, convened at nine thirty-five o'clock, Dr. M. S. Henderson, Rochester, Minnesota, the president, presiding.

PRESIDENT HENDERSON: The meeting will please come to order.

We have appointed a Credentials Committee consisting of Dr. A. B. Stewart, Dr. P. A. Lommen and Dr. H. M. Blegen. They should report. Is Dr. Stewart here?

DR. A. B. STEWART: The Credentials Committee is pleased to report that thirty delegates from sixty counties handed in their credentials. If any are here who have not handed in their credentials, please do so. We ask to be continued with the privilege of reporting later.

PRESIDENT HENDERSON: There are sufficient delegates who have presented credentials to constitute a quorum, so I hereby declare the House of Delegates in session.

Our first order of business is to welcome any guests who are here. Do any of you have any guests with you? As they come in we will greet them.

The next order of business is the acceptance of the minutes of the last session as transcribed by the official reporter and published in full in the September, 1931, Minnesota Medicine. These are long and voluminous and it would take considerable time to read, and the Chair would welcome a motion to pass it by and have them accepted as published.

DR. H. M. WORKMAN (Tracy): I make such a motion, Mr. President.

DR. F. A. WILLIUS (Rochester): I second the motion.

PRESIDENT HENDERSON: It is moved and seconded that the minutes be acecpted as published. Is there any discussion?

The motion was put to a vote and carried.

PRESIDENT HENDERSON: The next order of business is the report of the Chairman of the Council, Dr. Workman.

Dr. H. M. Workman read his report as Chairman of the Council.

REPORT OF THE COUNCIL

The Council of the Minnesota State Medical Association met at 6:30 P. M. Sunday, May 22, at the Lowry Hotel, St. Paul.

The Chairman, Dr. H. M. Workman, presided.

The following were present: Dr. M. S. Henderson, Dr. H. M. Workman, Dr. H. Z. Giffin, Dr. W. A. Coventry, Dr. F. J. Savage, Dr. S. Boyer, Dr. W. W. Will, Dr. O. J. Hagen, Dr. W. A. Piper, Dr. H. M. Johnson, Dr. L. Sogge, Dr. E. A. Meyerding.

The Reference Committee, consisting of Dr. A. N. Collins, Chairman, Dr. O. E. Locken, Dr. R. V. Williams, Dr. W. C. Carroll, Dr. C. B. Wright met with the Council for dinner and discussed the reports of the various committees.

A committee representing the Minnesota State Masseurs' and Masseuses' Association presented their situation with regard to the desirability of establishing a school for the teaching of massage at the University of Minnesota.

Mr. J. R. Bruce and Dr. J. T. Christison, Chairman of the Editing and Publishing Comimttee reported on the amalgamation of MINNESOTA MEDICINE and the Journal-Lancet. It was left to the Council to take further action.

The minutes of the last meeting of the Council were read and approved.

The Secretary reported on the cost of the annual meeting to date, also the Commercial Exhibits.

The Secretary reported on the membership.

Dr. Savage gave a brief report on the finances.

Applications for Affiliate Memberships were considered.

It was decided by the Council to accept Dr. J. A. Malerich's application for membership in Houston-Fillmore County Medical Society.

The Secretary reported on the situation in Stearns-Benton County.

Delegates to the A. M. A. were nominated. Dr. H. M. Johnson, delegate; Dr. E. A. Meyerding, alternate. Dr. W. F. Braasch, delegate; Dr. W. L. Burnap, alternate.

The Secretary reported on the exchange of medical journals between Wisconsin and Minnesota.

The Secretary read a letter from Dr. J. M. Armstrong of the Editing and Publishing Committee regarding the Journal-Lancet.

The Secretary reported on correspondence with Ramsey County regarding bids on badges, et cetera.

The Secretary read correspondence regarding St. Luke's Hospital at Thief River Falls.

The Secretary read a letter from Dr. J. A. Cosgriff of Olivia regarding "Care of the Indigent."

The Secretary reported on the bond of Mr. J. Robert Bruce.

Dr. T. M. Johnson gave a report on the New Orleans meeting.

The Secretary read a letter from Dr. A. J. Chesley, State Department of Health, regarding White-House-Minnesota Conference on Child Health and Protection.

The meeting adjourned.

DR. WORKMAN: I move the adoption of the report.

The motion was regularly seconded.

PRESIDENT HENDERSON: Is there any discussion or corrections?

The motion was put to a vote and carried.

PRESIDENT HENDERSON: As the next order of business, I am going to ask Dr. Arthur Collins, Chairman of the Reference Committee, to discuss the Council reports.

DR. A. N. COLLINS (Duluth): The Council reports from the First, Second, Third, Fifth, Seventh, Eighth and Ninth Districts were submitted. There were no comments recorded by the Reference Committee on these reports excepting the fact that the report of Ramsey County, Dr. Savage's report of the Fifth District, went rather deeply into the matter of program in this district. We held up our action for a few hours until we met with the Council, at which time Dr. Savage asked whether this conflicted at all with the state program, and we said it did not. So that was approved.

You may have one of the first drafts of the report of the Eight District, Dr. Hagen's district, but there is a central paragraph of the Red River Valley Society

which has been stricken out of his report. Otherwise, the reports of the Councilors were accepted.

PRESIDENT HENDERSON: You have heard the comments of the Reference Committee. Have any of the individual Councilors concerned anything they would like to add or say? We would like to hear from you if you have.

The next order of business is the report of your President. I am not going to say much. You will have to listen to me on Tuesday night. The By-laws say the President must deliver an address, so I have to and you will have to listen then. However, I wish to assure the House of Delegates of my appreciation of the opportunity to serve you as your President. It has been a great pleasure to meet the men around the state and I have a deeper appreciation than ever of the worth of the men in the State Medical Association. I would like to pay tribute, too, to the men who have worked so well on the committees, one and all, for they have shown great willingness to give of their time freely, and oftentimes at a sacrifice to come to the meetings, and I think we are really accomplishing something.

I thing the Committee on Scientific Assembly particularly has been busy this year. We had a number of meetings early in the year, usually on Saturday nights when most men might want to stay home with their families or gather around with some friends on convivial occasions, but they have given that up and come to these meetings, and the meetings lasted late into the night, and they went home then to carry on correspondence and assemble this program that I think you will agree is certainly varied and entertaining.

Dr. Meyerding and Dr. O'Brien have been very valuable, and Dr. Donohue in St. Paul. I should just like to bring one thing to your attention, that the Committee on Scientific Assembly changes its entire personnel practically each year, so that the question of continuity falls pretty heavily on the shoulders of our Secretary. He has to sit in at those meetings and sort of line us up and head us in the right, and this year with the assistance of Dr. O'Brien, I think we are ready to get down to business and do things expeditiously and not waste too much time. I think there is some need for the establishment of a continuity in that committee, some rotating membership.

I have endeavored to visit the different societies around the state and have appreciated the opportunity to meet the men, and I will be glad to attend as many society meetings as I can, but I think the Councilor of each district should attend these meetings also for I think it helps to keep up interest in the Society.

I suppose the balance of the year, of course, will go on without much excitement. The legislative elections are this fall, and I think our Legislative Committee will keep us informed as to who the men are that we should vote for, men who are friends of the medical association, and while we cannot do any out-and-out campaigning, I think it is up to us to watch the personnel of our legislative body.

The next order of business is the report of the Secretary, Dr. E. A. Meyerding.

REPORT OF THE SECRETARY

The year of 1931 has been distinguished by the influx of inquiries and activities on the part of various committee chairmen. This sudden increase in the amount of office work is undoubtedly due to the fact that greater time has been available for the consideration of these matters.

The demand for information and service is of a type that is more complicated than formerly. The local societies and groups of doctors are studying certain problems and require a great deal of intricate and special information.

COMMITTEES

The committees have, as a whole, been somewhat more active than in previous years. You will agree that the Scientific Program Committee for 1932 has undoubtedly created the best annual meeting in our history. The Public Health Education Committee has followed out the suggestions submitted a year ago in that it has subdivided itself into several sub-committees consisting of the Executive Committee, Liaison Editorial Association Committee, Liaison Heart Committee, Liaison State Health Relations Committee, Committee on Child Welfare, Editorial Committee, Eye, Ear, Nose and Throat Committee, Committee on Speakers Bureau, and Tuberculosis Committee.

NEWSPAPER SERVICE

This service is being accepted as in the past, and we believe it is becoming more valuable all the time. The total number of papers accepting this service is 300. It is urged that members ask their newspapers why they do not publish these stories, if they do not, and when the stories do appear, that they congratulate the editor.

STATE BOARD OF MEDICAL EXAMINERS

A close contact has been kept with the Secretary of the State Board of Medical Examiners and the Basic Science Board. Frequently communications come into this office that must be referred to the Board of Medical Examiners, and requests for information from them are furnished regularly. We wish to express our appreciation to the State Board of Medical Examiners, its secretary, and staff.

COMMITTEE ON HOSPITAL AND MEDICAL EDUCATION

This committee has been active in the past year in furthering the Short Courses. The Short Courses are holding their own, and it is a great compliment to the profession of Minnesota that so many of its members are interested in this means of scientific advancement.

THE PRESIDENT

President M. S. Henderson is likely to hold the record over all previous presidents for attendance at county medical society meetings.

Doctor Henderson has been very active in the conduct of his office, having made more personal contacts with the membership, already, than many of his predecessors.

PAST PRESIDENTS

For a long time it has seemed a great waste to lose abruptly the services of the men who have served as presidents at the expiration of their short terms. A good deal of thought has been given to the subject as to how to take advantage of the knowledge and experience attained by a member who has gone through the various offices culminating as President.

It is suggested that there be added to the Council four additional members consisting of the four past presidents whose terms have last expired. We believe that in this way we shall retain this all-valuable service of the men who know most about our program, history and precedents established.

SEVENTY-EIGHTH ANNUAL MEETING IN MINNEAPOLIS

This meeting was successful in practically every respect. It was apparent that the meeting place was not quite large enough. The local committees were very cooperative and very hospitable. The total attendance was 896, the largest attendance ever held by this organization, in contra-distinction to other organizations who at that time had been falling off everywhere from 25 to 50 per cent of their regular registration.

HEADQUARTERS

The present arrangement of coöperation with the Minnesota Public Health Association continues to be of equal importance to both organizations. Their publication, *Everybody's Health,* is conducted on as high an ethical plane as possible, to their financial loss. We will leave it to the medical profession to keep in mind and further the program of the Minnesota Public Health Association as much as it can. The profession should keep always in mind, also, the value of a publication such as *Everybody's Health* which goes to every school, hospital, library and to many homes throughout the state, and which not only is ethical, but constantly carries on a program to create goodwill toward the practicing physician.

HEALTH MEETINGS

Speakers have been sent out by the Public Health Education Committee to various parts of the state and to various organizations, such as the Parent-Teacher Associations, Women's Federation, et cetera. Health meetings were also conducted, in conjunction with the Minnesota Public Health Association, in various parts of the State.

STATE SECRETARIES' CONFERENCE

The largest and most interesting Secretaries' Conference in the history of the association convened at the Saint Paul Hotel, January 23, this year. Three main subjects of very vital importance to the future of medicine in America occupied the largest share of the day and held the majority of the delegates for discussion long after the scheduled hours of adjournment. These subjects were "Medical Care of the Poor"; the "Periodic Medical Examination" and "Medical and Hospital Care for Veterans." Nine states including Minnesota, Wisconsin, Illinois, Iowa, Nebraska, Wyoming, North and South Dakota and Michigan were represented at this meeting and at the Northwest Regional Conference which occupied the Sunday following.

REGIONAL CONFERENCE

An informal exchange of views and policies between officers of all nine organizations marked the Regional Conference which annually follows the secretaries' meeting. Public Health Education, Medical Group Advertising, Medical Care of the Poor, Public Relations and Veterans' Care were among the subjects discussed.

MEDICAL CARE OF THE VETERANS

Your Secretary was appointed a member of the Auxiliary Committee of the American Medical Association to study this question. He traveled with the chairman of the committee, Dr. C. B. Wright, to Chicago, Indianapolis and Washington several times, and sat in at the various conferences. Minnesota can be justly proud of the active part it has taken in this great movement for better health protection for those who made their sacrifice to safeguard our nation.

Your Secretary also assisted Drs. Theodore Sweetser, H. R. Tregilgas, C. B. Wright and N. G. Mortenson in framing a resolution to be suggested for passage by Minnesota Legion Posts, urging the liberalization of the law to permit medical and surgical emergencies of veterans to be cared for in civilian hospitals. The resolution is similar to others passed by a large number of Posts in other parts of the country, including some of the 40 and 8's.

RADIO PROGRAM

Dr. W. A. O'Brien entered his fourth year of weekly broadcasts on health under the auspices of the state association this year. The steady popularity of these talks is attested by the volume of mail that continues to come in in response. Their widespread educational value is beyond question.

AUXILIARY

Your Auxiliary is taking a leading place in organization, membership and enlightened program among all of the auxiliaries affiliated with the American Medical Association. As an invaluable agency of public health education it merits the most cordial and interested support on the part of the medical profession.

FISCAL YEAR OF THE COMPONENT MEDICAL SOCIETIES

The membership of the component societies has kept up remarkably to the standard of last year. In April there were only about 30 less members than the post-meeting total for 1931. Undoubtedly, the post-meeting total for this year will equal, if not exceed, the last. The continued strength and effectiveness of our association will depend, of course, upon the continued enrolment of new members in our ranks.

AMENDMENTS TO CONSTITUTION AND BY-LAWS

It is proposed this year that Articles VI and IX be amended to allow the past presidents for four preceding years automatically to become members of the Council. According to the proposed amendment, these men would serve for the four ensuing years, so that, besides the president, the councilors from the regular districts and the secretary and treasurer serving ex-officio, there would always be four additional members.

NEW SOCIETY

An important consolidation of two large societies has marked the year. The Chisago-Pine County Medical Society united with the Central Minnesota Medical Society under the joint name of the East Central Minnesota Medical Society.

ROSTER TO PROBATE JUDGES

The roster was sent to members in each county seat with the request that they give it personally to the Judge of Probate of their counties. In response to a questionnaire from the state office these members reported a vast majority of the judges of the state to be friendly to organized medicine and the state association. A few appeared to be indifferent. Three of these were reported in their dotage and generally unresponsive. Three others were reported as occasionally calling on members for testimony in their courts. No active opposition was reported from any quarter.

THE 1932 MEETINGS

The following extract from Dr. Locken's report of the recomendations of the Special Committee to Study the Policies of the state association was passed by the House of Delegates last spring:

"That all arrangements for the Annual Meeting shall be handled by the State Central Office and by the State Committee with the exception of such matters of entertainment as the local host city is prepared to give. That income from commercial exhibits go to the State Association and that it, in turn, correspondingly assume expenses for the meeting."

As indicated by the above, the Commercial, Scientific and other Exhibits were placed in the hands of the Secretary's office this year. These duties have added considerable to the work of the Secretary's office.

1932 was not a good year to make a showing with commercial advertisers. Great difficulty was encountered in selling space because of the curtailment in advertising budgets of many business firms. We believe, however, that this arrangement has been conducive to the development of our educational program and that, eventually, it will be to our financial advantage as well.

The 1932 program is obviously a marked departure from the programs of former years. Its success, if it is successful, will be due in great part to the centralization of activities. The members will be able to judge for themselves.

RECOGNITION OF MINNESOTA'S SUPERIORITY

Minnesota medical men are being recognized more and more by national medical organizations. You will find many of them presidents and officers, also chairmen and members of important committees. In our own American Medical Association, we have the President of the Association, the Chairman of the Legislative Committee, the Chairman of the Reference Committee, not to say anything of the numerous officers in the various sections. One can be justly proud in any medical group to say, "I am from Minnesota."

There is no question in our minds that the progress that has been made in regard to curtailing the activities of the U. S. Veterans Bureau in their hospital building program would never have been successful if the Minnesota medical profession had not been prepared, through their experience in legislative matters, to advise and assist our national organization.

CONCLUSION

No Secretary's report is complete without proper acknowledgment of the work of the County Society officers. Holding office efficiently in a county society, especially that of county secretary, entails accurate bookkeeping, conscientious reporting of dues, meetings, and deaths, an executive ability and a prodigious fund of tact and affability, all of which seemed happily combined in those who served during the year 1931.

Our observations lead us to believe that the medical profession of the State of Minnesota compares favorably with other states. Our members are more active, better informed and more efficient in carrying out not only scientific, but many medical and social problems.

SECRETARY MEYERDING: Mr. President and gentlemen: The report of the Secretary, as all of the reports, has been sent to every delegate. Therefore, we will not read the report here except such parts as we wish to emphasize and bring up such supplementary matter as we may have.

I would like to read this paragraph: "There is no question in our minds that the progress that has been made in regard to curtailing the activities of the U. S. Veterans Bureau in their hospital building program would never have been successful if the Minnesota medical profession had not been prepared, through their experience in legislative matters, to advise and assist our national organization." If it be true (and it is already apparent) that the building of federal hospitals for veterans will be curtailed, you can feel that the glory belongs to you for initiating and carrying out most of the part that has been successful.

I also want to call your attention to this meeting. We are at the cross roads in our annual meeting. This year we are in a new type of meeting. It is for you to say whether we shall continue with this type of meeting or go back to the type we had before. I will explain.

You have seen your program. It is a much broader and extensive program than we have ever attempted before. You find we have from three to thirty different subjects going at once. Just remember that that costs money. When we had one meeting hall we required one reporter, and proportionately the expense was so much less. The minute you have other additional meetings at the same time your expense goes up. It doesn't double or triple each time, but it goes up in proportion.

We also have inaugurated what we call our technical exhibits, downstairs. That is a mixture of commercial and scientific exhibits. If we are to continue this, it will be necessary that we have meetings in places where we can have proper housing facilities, and they are not available in every part of the state. If you think this is the type of meeting that you want, you should vote on it at your Tuesday meeting tomorrow and consider where the meetings go, so that we shall have facilities.

I think more power should be given to the committee that works throughout the year. This year it was Dr. Savage and myself, I believe, and we called the President in. It should be similar to the system in the A. M. A., so that we can turn down a place if they cannot provide the facilities or do not give us what we think we should have. It has cost us a little matter of $500 that we didn't expect in St. Paul due to the fact that they insisted on our paying for the space we sold. That sounds sort of reasonable. If we are going to make some money we ought to pay for it. Personally, I think we are enough of an inducement to any city that they could give us the necessary space. It would not amount to $500. It might amount to $300 or $200, but I believe they should have given us that space.

Those are things which I mean might come up, and your committee should have the power to select a place or change the place if necessary. I think if we had had that power we would not have had to pay for the space we sold downstairs.

I asked you please to consider this meeting. You will get a better idea by tomorrow morning, because the sessions open this afternoon. If that is the type of meeting you want we should very carefully consider where the meetings go. The meetings with the exhibits are costing us less out of our treasury than they did previously. This is an unusually bad year from an economic standpoint. It is very difficult to get commercial exhibitors, not only because of economic conditions but for other reasons. One group combined not to exhibit with the Minnesota State Medical Association any more. The optical people got together and refused to exhibit with us for reasons they had or believed they had. So inspite of that, this meeting, which is much greater than any we have ever had, is costing our treasury less. I hope you will consider this matter carefully.

Personally I believe the only place you can have a real meeting is in St. Paul. We have an auditorium here that is better than any other in the state. It is possible we might have the meeting in Minneapolis with great difficulty. Thank you.

PRESIDENT HENDERSON: It probably is not necessary to tell you that Dr. Meyerding was born in St. Paul and he never got over it.

You have heard the report of the Secretary. What shall I do with it?

DR. WORKMAN: I move its adoption.

The motion was regularly seconded.

DR. A. G. SCHULZE (St. Paul): The Secretary's report as presented to the delegates includes a great deal more than was given from the platform. On the second page there is this paragraph under "Past Presidents": (Perhaps it isn't necessary to read that, except the second paragraph.)

"It is suggested that there be added to the Council four additional members consisting of the four past presidents whose terms have last expired. We believe that in this way we shall retain this all-valuable service of the men who know most about our program, history and precedents established."

I think that is very true. Perhaps there is nothing that is truer.

In the paragraph preceding the one I just read, it is given that the purpose of this is to not lose abruptly the services of the men who have served, at the expiration of their short terms. The idea is to retain these men for a period of four years longer, to give of their wisdom and of their judgment to the Council. I think that is very good. The Councilors now consist of the

nine Councilors, together with the President, the President-elect and the Secretary and Treasurer as ex-officio members. We add four more to that, which makes thirteen, and with the officers, the President, President-elect, Secretary and Treasurer, it is seventeen.

Personally I feel there is more and more of the business of the Association taken out of the hands of the delegates and placed in the hands of the Councilors. That may be all right, but there is a limit to it, I think. I am very willing to vote for that clause, but with this amendment: "That these past presidents be regarded as advisory members of the Council." The Council is composed of three bodies, we will say: the Councilors, one man from each of the nine districts; the officials, which are the President, President-elect, Secretary and Treasurer, ex-officio; and now the four past presidents who shall be the advisory members, we will say. But I would amend it to the extent that these men be without a vote in the Council or in the House of Delegates, serving purely as an advisory committee.

PRESIDENT HENDERSON: I might call on Dr. Collins as chairman of the Reference Committee, who might comment on this. This has all been gone over by the Reference Committee and I think we will embody the things we speak of.

DR. COLLINS: When we come to take up the various amendments don't you think the discussion will be on these particular points?

PRESIDENT HENDERSON: This report of Dr. Meyerding is merely a report, and these things mentioned in it will come up as we go along in the ordinary run of business, and I think you will find this will be taken up by the Reference Committee, Dr. Schulze.

DR. SCHULZE: That is perfectly all right. I thought you were about to call for the adoption of the report.

PRESIDENT HENDERSON: I have to call for the adoption of the report, but it doesn't change the Constitution in any way.

DR. W. A. COVENTRY (Duluth). The report is just an opinion on the part of the Secretary and is not binding on this body until adopted as a binding part of our Constitution. Just to adopt the report is simply adoption or receiving his recommendations and taking them for what they are worth.

The motion was put to a vote and carried.

PRESIDENT HENDERSON: Report of the Committee on Public Health Education, Dr. Critchfield.

REPORT OF THE PUBLIC HEALTH EDUCATION COMMITTEE

The Committee has developed this year from a large, somewhat unwieldy organization, in which (of necessity) a few did the work for the entire body, into a group of small working units.

This, in the opinion of the Chairman, is an important step in advance which the ever widening scope of the committee's activities has made necessary. It will facilitate all of the work of the committee. It will involve all members in a responsible direct part in the work and much more closely than formerly bind its facilities to other committees of the state association.

The Committee on Public Health Education as now constituted is made up of an Executive Committee including chairmen of all the committee sub-divisions; an Editorial Committee, an Eye, Ear, Nose and Throat Committee; a Committee on Speaker's Bureau; a Tuberculosis Committee; and a Committee on Child Welfare. In addition there is a Liaison Editorial Association Committee; a Liaison Heart Committee; a Liaison State Health Relations Committee. These liaison committees are designed to coöperate actively and closely with corresponding committees of the State Association in all the phases of their work that concern education of the profession or the public.

EXPENDITURES

We are presenting a financial statement that shows various expenditures under definite heads. Where expenditures are listed to accounts that are not primarily the function of this Committee, they were charged at the request of the Council. Our total annual budget expenditure is therefore a financial statement of the activities of our committee plus certain other outlays especially voted by the Council.

FINANCIAL REPORT

1931 Analysis of the Public Health Education Expenditures

News Service	$1,268.78
Legislature—Hygeia & Everybody's Health	315.25
Stenographer	715.00
Radio	406.61
Miscellaneous Postage and Printed Matter	69.48
Speakers	66.00
Meetings—Public Health, Med. Econ., County Society, Officers Conf. P. T. A., Public Health Nurses, etc.	144.49
Sundries, Petty Cash, Telephone & Telegrams	13.14
Reprints of Public Health Education Paper read at A. M. A.	45.27
4-H Club Examination	70.50
4,000 Health Posters	72.00
Total	$3,186.52

NEWSPAPER SERVICE

The weekly newspaper service conducted by our Committee reaches 300 newspapers in the state. It receives the endorsement and commendation of the Minnesota Editorial Association. Thanks to facilities offered by our alliance with the Minnesota Public Health Association the service continues to be prepared and sent out from the State Office. The Editorial sub-committee of which Dr. H. F. Helmholz is chairman carefully censors and revises each bulletin bearing our endorsement.

MEETINGS

Medical Economics Meetings, Public Health Meetings, County Society Meetings, Conferences, Public Health Nurses' Meetings.

Various members of the association spoke at meetings of the above character in different parts of the state. Their travelling expenses for these trips were paid by this Committee.

STENOGRAPHER

The Committee has paid only a share of the salary of one employee at the State Office this year in place of assuming the entire charge as formerly. In accordance with the new pro-rata arrangement inaugurated in 1931 the salary is now distributed in accordance with comparative services rendered.

SPEAKERS' LIBRARY MATERIAL

The Speakers' Library is in almost constant demand by members with public health talks to give in every part of the state. Material for this library is collected from periodicals, government printed material, current publications of all sorts as well as popular new books. It is available to all members at any time.

RADIO

The Committee wishes to congratulate both itself and Dr. O'Brien on the continued popularity of his weekly radio talks, which are now in their fourth year on WCCO. This series is undoubtedly still the most popular public health feature in this section of the radio

world. Incidentally, abstracts of the talks appear each month in *Everybody's Health,* Minnesota Public Health Association publication, and are supplied through the latter to all radio listeners applying for them.

LEGISLATURE—HYGEIA AND EVERYBODY'S HEALTH

As in former years we have sent *Hygeia* and *Everybody's Health* during the past year to all members of the Minnesota State Legislature.

REPRINTS OF PUBLIC HEALTH EDUCATION PAPER READ AT CHICAGO

This paper, given by Dr. E. A. Meyerding at the 1931 Secretaries' Conference in Chicago, was in fact a complete outline of the history and operation and aims of this Committee. It had the assistance and endorsement in its preparation of the Minnesota leaders who organized the committee and the public health work of the association. Reprints of it have been found useful not only to send to other states interested in our form of joint organization with the public health association but for the education of our own membership and of public health officials.

4-H CLUB EXAMINATION

Close to 200 boys and girls, members of 4-H Clubs in Minnesota, were examined last fall at the joint headquarters of the State Association and the Minnesota Public Health Association, with the object of picking the healthiest and best developed to represent Minnesota at a National contest in Chicago. A very complete, well organized examination was given these boys and girls by 10 specialists under the direction of Dr. Meyerding. As a whole they were a group of fine physical specimens doing credit to the practitioners throughout the state who had selected and in some cases, assisted to groom them for the contest. The Committee considers the contact with 4-H Club members and their directors and officials a very valuable one for physicians. An important avenue for future public health work and future contacts was undoubtedly established by this examination.

TUBERCULIN TESTING

The Committee has coöperated wherever possible with the program of tuberculin testing of school children carried on by the Minnesota Public Health Association this year. We heartily endorse this program not only as an essential step in the eventual control of tuberculosis but as a valuable aid in the education of the public to the importance of the repeated physical checkup by the family physician. These testing programs have brought to the doctor's office many a child who might otherwise never have reached there until too ill to be helped.

PERIODIC MEDICAL EXAMINATIONS

New diagnostic tools such as the Schick test, the Tuberculin and Wassermann tests, that modern medical science is constantly putting into our hands have created a new demand on the part of the lay public for the periodic medical examination. Great public health educational campaigns in Heart Disease, Diphtheria, Tuberculosis, and Cancer have contributed to the demand. In our own state the recent epidemics of influenza and poliomyelitis have multiplied the numbers of such campaigns in recent years. The result has been a growing demand, also, for medical follow-up.

The promotion of this essential corollary to modern preventive medicine is rightly the business of this Committee. We have assisted through our regular channels in the education of the public to this essential health habit. We have also led in the equally essential education of the physician in the proper scope and aim of this comparatively new phase of medical practice which is the obvious foundation of the medical practice of the future.

HEALTH POSTERS

Four thousand Health Posters of unusually effective design were purchased and distributed during the year in schools, public waiting rooms, factories, and shops.

One bore the legend over the picture, "He who treats himself has a fool for a doctor." Two thousand of these posters were distributed.

The other was a vivid, well colored picture of Chanticleer crowing at dawn carrying with it an appeal for proper hours of sleep and healthy vigorous living. Two thousand of these were distributed also.

HEART WORK

Education in heart work has a two-fold aspect. The Committee deems it an important part of its work, now and in the future, to facilitate as much as possible through its Liaison Heart Committee, the work of the State Heart Committee. Speakers for County medical society meetings, selected by the Heart Committee, have been and will continue to be booked through this Committee for the furtherance of the general association heart program. This phase of the program is regarded as especially important. Public Health Education in matters of heart disease and prevention is carried on through the usual channels according to the discretion of the Editorial Committee.

MENTAL HYGIENE

The increasing interest in mental hygiene is being shown by lay and medical groups. In order to lead in advancing this particular phase of preventive medicine, members of this organization must keep themselves in touch with the progress made by leaders. We must be prepared to offer intelligent advice regarding management of behavior problems of both normal and abnormal children.

Undoubtedly a very high percentage of anti-social behavior of adults can be prevented by correct management during childhood.

TALKS BY THE CHAIRMAN

Your chairman has spoken before the Committee Chairman's meeting of February 29; before the Public Health Nurses, March 22, at the University, and before the Washington County Medical Society, April 12, since he took office in February of this year.

LAY HEALTH GROUPS

Your Committee has continued to forward the policy inaugurated some years ago offering its counsel and cooperation to lay health and other interested groups. In pursuance of this policy we have furnished speakers for the Annual State Meeting of the Parent Teachers' Association; to Federated Club Meetings; to American Legion Posts; Public Health Nurses' Meetings; the Minnesota Editorial Association; the Conference of Social Workers and many similar groups.

The importance of our contact with the Minnesota Public Health Association cannot be over estimated and we wish to congratulate and commend all of our members for their coöperation in cementing this contact all over the State. Theirs is the credit for the good feeling which exists everywhere between lay members of the Minnesota Public Health Association and their medical associates.

CONCLUSION

The obligation of the medical profession to assume leadership in public health activities and public health education becomes more urgent with each passing year.

The Committee feels that its work is of the utmost importance to the welfare of the association and that money is well spent on behalf of these activities.

DR. L. R. CRITCHFIELD (St. Paul): I have a very brief addition to my report. The work of this committee has been facilitated very much by the fact that we have almost a unique situation. The association between the state association and the state public health association is very close. The executive offices come together.

By using the organ, the magazine, *Everybody's Health*, this committee has been able to further public health education very considerably. There have been some attempts from various parts of the state to possibly disintegrate this Association, and I have not embodied in my formal report anything about this, but I thought I would like to bring it up on the floor. We are in hopes that the members of this body particularly will use their influence to further continue the agreeable and active association between the Minnesota Public Health Association and the State Medical Association.

This committee has been given a very great impetus. A fine piece of work has been done by our predecessors on the committee, and we hope we will be able to continue, but we feel it is absolutely essential that the physicians throughout the state understand and know something about the program and be willing to engage actively in furthering it. We feel the physicians should make it a business to be active in their local public health associations in order to keep up their relationship. You doubtless know (if you don't you should be informed) that there are plenty of agencies just reaching out, anxious to take charge of and control public health education. Just recently one of the groups of the state, the Optometrists Association, have been able to put half-page advertisements in the Parent-Teacher Association Magazine. They are anxious to get hold of that part of public health education. The laity are just eager to get all the information possible. That makes it easy for our organization, if we will take charge and remain in charge as we should, because we have instituted all medical progress. So I am just presenting this outside of my formal report.

PRESIDENT HENDERSON: Dr. Collins.

DR. COLLINS: The Reference Committee has considered the report of the Public Health Education Committee. Included in this report is the itemized account of expenditures for 1931.

We accept this report and recommend its acceptance by the House of Delegates.

The Reference Committee wishes to congratulate the Association and Dr. O'Brien on the continued popularity of his weekly radio talks, which are now in their fourth year over WCCO. These talks are undoubtedly the most popular public health feature in this section of the world.

Dr. Meyerding read a paper at the Secretaries' Conference in Chicago, in 1931, outlining the history, operation and aims of the Public Health Education Committee. This report was well received. Reprints of this paper have been found not only useful to other states interested, but for education of our own membership and other public health officials.

The program for the tuberculin testing of school children is endorsed in the report as an essential step in the eventual control of tuberculosis; also as an aid to public education regarding tuberculosis. These testing programs have brought to the doctor's office many a child who might otherwise never have reached there until too late to be helped.

Education in heart work has been stimulated through the work of the Speakers' Bureau of the Heart Committee, and will be continued throughout the coming year. This phase of the heart work program seems very important.

In conclusion, the Reference Committee would like to commend the splendid work of the Public Health Education Committee on such a small expenditure of money. Many states spend three or four times as much on this type of work. It should be considered one of the most important parts of the work of the state association.

PRESIDENT HENDERSON: You have heard the report of the Reference Committee. We would like to have discussion of these things. Is there any discussion?

SECRETARY MEYERDING: Your liaison with the Minnesota Public Health Association and the Christmas seal organization has been going on for the past seven years, approximately. Personally I think that is all-important as a great factor in making your state medical association what it is today. Today you practically control medical leadership, or rather the health work is conducted by medical leadership. That is not true in most states. Lay leadership is frequently most prominent, by which I mean interested laymen such as social workers. We have that in this state also, the group who also desire to assume that leadership, but due to the strong character we had in Dr. H. Longstreet Taylor, that never came about. Unfortunately Dr. Taylor has passed away, and we are beginning to feel the attempted advances being made by other groups.

I think the medical profession has a greater influence in that it is so closely allied with this organization. I will mention just one part of the program of the Public Health Association and that is this little magazine. There are plenty of copies downstairs for you to take, and I hope you will take the last two numbers and look through them. That will be enough to say about this one part of their program, which probably takes approximately one-fifth of our budget of the Public Health Association and for which you pay not one cent from your dues. Just look through the journal and see the type of material that goes to every school, every hospital. In St. Paul alone there is a circulation of over 3,000. Every doctor's and dentist's office, every reading room, every library, every place where there is a group, gets that journal at no expense to you.

I forgot to say something previously in my own report that I heard on the way to New Orleans that will be of interest to all of you. Mr. Crownhart, Secretary of Wisconsin, said he would come this morning if he possibly could, but I do not think he can make it. In Wisconsin they have an income tax, and the records of the income tax are filed in each county. The State Medical Society, in studying their problems, decided to make a survey of the incomes of the doctors in Wisconsin. They could get a more accurate survey there than any other place in this country. They hired some individuals, I believe they were connected with the University of Wisconsin, who went to every county and got the reports, with the result that they know in Wisconsin today that the gross income of the medical profession of Wisconsin is $17,500,000 for the year 1931.

You are unable to get that information in Minnesota or any other state that I know of. Mr. Crownhart is a layman, an ex-newspaper man. He said, "You know these doctors don't pay anything for protection. The dues they pay to their society to protect the $17,500,000 worth of business is just exactly seventeen ten-thousandths of one per cent." That is what the medical profession of Wisconsin pays to look after its business, such as legislative, public contact, and so forth.

The same thing applies in Minnesota. We are approximately the same size, but I think we do at least twenty-five per cent more medical business, so we probably are paying a little less than they are. We are

better organized than Wisconsin, and the reason for that is that we have this contact with this organization and can control various lay health activities.

I want to commend Dr. Critchfield for the splendid work he has done. He has a big job on his hands and he divides his committee into subcommittees. He is the whole medical association himself with his committee, apparently. They are all working and doing a splendid piece of work.

Here is the Parent-Teacher Association. I wager fifty per cent of you belong to it. I belong to it myself. Yet we cannot control our state publication which goes to every parent-teacher member in the state, to keep it from placing ads of the type spoken of. The optometrists have been running a two-column ad in that publication for a long time, and we get letters from all over the state complaining about it. We cannot stop it. I don't know how to stop it, unless the Auxiliary get in and run the P. T. A. like you are running the M. P. H. A., the Minnesota Public Health Association, today.

PRESIDENT HENDERSON: Is there further discussion?

DR. H. M. JOHNSON (Dawson): Mr. President and Members of the House of Delegates: I would like to say a few words in regard to that, because one of our greatest troubles in the earlier days of the state medical association was that we had so many different health groups. There was no way to control them. They had this, and they had that, all over the state, one kind of clinic under one head, and one kind of diagnostic center under another head, and it was simply beyond anybody's control. It was controlled by laymen and they had no respect or regard for the medical profession, no matter where they were.

I want to say this: Out in the country, the doctors got so disgusted, so entirely disgusted with this kind of clinics and advisers that were sent out without the consent or advice of the medical authorities at all, that they felt like throwing up the whole state medical association.

One of the first things that had to be done to get the state medical association on its feet was to devise some ways or means whereby these different organizations could be made to work under one head, and that head to be controlled more or less by medical men. After due consideration and a good deal of study, this Public Health Committee was finally devised. It was appointed before we really had a right to do it, but it was an emergency measure and has worked out fine.

I want to say this to you: If we let anybody encroach on the funds for the Public Health Association in its local activities, it cannot be controlled. That will be spread and women here and there all over the state are going to tell the doctors what kind of clinics they want and how they want the money spent. It cannot be controlled locally. It simply has to be controlled from one head. Everything has to go into the Public Health Association, and through the connections that they have now with the state secretary and other men in the public health work. It has been working fine. I don't think there is any state in the United States that is so well controlled, and so far advanced in public health work, under the control of the medical profession, as this state. I want to say the happiest combination that has existed and can ever exist is when we can have a secretary of the state association and also of the Public Health Association who can work hand-in-hand and get these things controlled. If we do not, they are going to run us. You can just make up your mind to that. You know what that will be, if the laymen are going to dictate the public health policies of this country.

I hope everybody will take it upon himself to see that the Public Health Association is supported as a unit. There must be one center of activity and that must be guarded and guided by the men at the head of it.

I think the Public Health Committee as a whole has done wonderful work. It was a hard thing to start, but great credit goes to all the members on the committee, especially the various chairmen, and I hope the work can and will go forward in the same splendid and advancing way as it has.

DR. GEORGE EARL (St. Paul): It has been a great pleasure this year to have had a place on this Public Health Education Committee under Dr. Critchfield, after having been chairman some five years.

On the one hand, in the question of health relations, we have organized medicine, which means we of the Minnesota State Medical Association are expending, as was quoted here today, an infinitesimal sum in order to influence the question of health and in order to influence the relationship of us as practicing physicians on the question of health.

On the other hand, we have organized and unorganized forces also trying to influence the question of health. Witness Macfadden's Magazine, witness the anti-vivisectionists and anti-vaccinationists. Witness the honest, sincere, but misguided influences such as the Christian Science church. Witness the constant lobbying that is put in at every legislature in behalf of naturopaths and what-have-you.

I do not hesitate to mention economics because Benjamin Franklin is the authority for the saying that economics or economy is the root of all progress. From an economic standpoint we certainly have a very definite task in influencing the question of health, but not necessarily from the selfish standpoint only of our own interests, although this too is a matter for which we do not have to apologize, because if the income is not reasonably sufficient your children and your grandchildren are not going to have the expert services of the highest type of medical science until the economic returns are reasonable.

All I want to say is that whenever we have an opportunity it is right that we should accept positions on the directorate or help to guide and influence these lay organizations in the question of health. So much has been said today about one instance (and it is simply one instance, the Minnesota State Public Health Association) that I am not going to say anything more about it. The way that has been developed is rather an ideal way, because the state and county boards of directors almost without exception are composed of, if not a majority, at least a large and influential number, so that here we have a direct influence and in the right direction on the question of health, and it is probably a matter that we do not appreciate enough.

PRESIDENT HENDERSON: Are there any further comments? If not, what will you do with the report?

DR. W. C. CARROLL (St. Paul): I move that it be adopted.

The motion was regularly seconded, put to a vote and carried.

PRESIDENT HENDERSON: Report of the Treasurer, Dr. Condit.

Dr. W. H. Condit read his report as Treasurer.

TREASURER'S REPORT FOR 1931

RECEIPTS

Balance on hand Dec. 31, 1930		$ 7,343.99
Dues collected, placed to checking fund	$19,747.58	
Placed to savings fund	12,330.00	32,077.58
Refund from Dr. Workman		400.00
Refund from Minn. Public Health Assn.		10.99
Interest on checking account	71.77	
Savings account	238.57	310.34
Total		$40,142.90
Total disbursements		$37,177.69

Balance on hand Dec. 31, 1931		$ 2,965.21
Outstanding checks		$ 350.50
Bank balance		$ 3,315.71

DISBURSEMENTS

Annual Meeting		$ 1,470.46
Minnesota Medicine:		
$4,000; 1930 deficit $1,493.12		5,493.12
Notes payable		2,000.00
Rent		300.00
Stenographers and clerks		2,064.91
Public Health Education Committee		3,186.52
Consultation Bureau		225.00
Treasurer's office:		
Salary $100.00, expense $1.57		101.57
Education Committee:		
Paid to Dr. Johnson	$10,800.00	
Paid to Dr. Workman	2,000.00	
Paid to Dr. Sogge	250.00	
Expenses	1,971.15	15,021.15
Secretary's traveling expenses		410,15
Secretary's salary		4,200.00
Conference of county secretaries		436.64
Interest expense		3.00
Hospital and Medical Education Comm.		14.88
State Health Relations Committee		5.07
Historical Committee		63.35
Council		267.77
Conferences		664.46
Miscellaneous Items:		
Office furniture, fixtures & expense	214.75	
Unbudgeted committees	150.26	
Postage	231.06	
Telephones	158.25	
Printing Matter	106.37	
Telegrams	13.22	
Minor miscellaneous	376.13	1,250.04
Total expenditures		$37,177.69

Of the above balance on hand Dec. 31, 1931, of $2,965.21, there must be deducted the sum of $915.00 representing 1932 dues, leaving $2,050.21.

STATEMENT OF THE SAVINGS FUND

Balance on hand Dec. 31, 1930		$ 4,984.46
Dues added to the savings fund		12,330.00
Interest on this account in 1931		238.57
Total		$17,553.03
Transferred to the checking fund Jan. 2	$ 2,000.00	
Apr. 1	5,000.00	
July 1	10,553.03	
Total		$17,553.03
Balance in this fund Dec. 31, 1931		None

STATEMENT OF THE CHECKING ACCOUNT

Balance on hand Dec. 31, 1930	$ 2,359.53
Dues added to this account	19,747.58
Interest on the checking account	71.77
Transferred from savings account	17,553.03
Refund from Dr. Workman	400.00
Minnesota Public Health Association	10.99
Total	$40,142.90
Total Disbursements	$37,177.69
Balance on hand Dec. 31, 1931	$ 2,965.21
Outstanding checks	$ 350.50
Bank Balance	$ 3,315.71

TREASURER'S REPORT

Period—December 31, 1931, to May 1, 1932

RECEIPTS

Balance on hand Dec. 31, 1931		$ 2,965.21
Dues collected:		
Deposited to checking fund	$17,167.00	
Interest on checking fund	22.49	$17,189.49
Total in checking fund		$20,154.70
Deposited to savings fund	$11,375.00	
Interest on savings fund	75.60	
Total in savings fund		$11,450.60
Total receipts		$31,605.30

DISBURSEMENTS

Annual Meeting		$	314.81
Conferences			145.25
Consultation Bureau			75.00
Council			167.07
Educational Fund			1,500.60
Historical Committee			137.40
Hospital and medicine			.....
Legal			.....
Minnesota Medicine			2,000.00
Public Health Education Committee			1,383.89
Rent			100.00
Secretary's Conference			528.31
Secretary's salary			1,400.00
Secretary's traveling expense			183.08
State Health Relations			.....
Stenographers and clerks			1,247.45
Treasurer's salary and expense			1.50
Miscellaneous items:			
Furniture and fixtures	$ 5.00		
Office supplies	50.25		
Postage	115.31		
Printed matter	91.19		
Telephone	87.15		
Telegraph	4.01		
Miscellaneous	177.45		
Unbudgeted committees	153.69		
			684.05
Bruce Publishing Company:			
Deficit for year 1931	1,726.26		
Payment 102 members over 2,000	204.00		
			1,930.26
Refunds overpayment of dues:			
Upper Miss. Val. Med. Soc.	37.00		
Wright Co. Med. Soc.	1.00		
Park Region Dist. and Co. Med. Soc.	3.00		
S. W. Minn. Med. Soc.	1.00		
			42.00
Total disbursements			$11,840.67
Balance on hand			$19,764.63

PRESIDENT HENDERSON: Dr. Collins, will you comment on the report?

DR. COLLINS: There is only one comment the Reference Committee has to make, and Dr. Locken will make it.

DR. O. E. LOCKEN (Crookston): In analyzing the report of the Treasurer the Reference Committee felt that there should be some additional information. You will notice that the entire savings account has been withdrawn and placed in the checking account. We want you to understand what that means. When a large amount of money is gotten in at the first of the year, as much of that as possible is put into a savings account to draw interest. As it is needed it is transferred back to the checking account so that it is used as indicated here. We thought possibly you would get the idea that the Association has used up all its money when it transferred its entire savings account, but this Association has what is called a fiscal agency fund which is really the reserve fund, and that today amounts to $24,679.26. That is the permanent reserve fund.

There is another item that the Reference Committee wanted to bring out. You will notice from the report that there was a deficit of $1,726.26 for Minnesota Medicine. The Publishing Committee have taken steps this year to meet that situation, so they have changed some of the expenditures and the report to the Council last night was that up to date, this year, 1932, there was a balance surplus of about $800, so that Minnesota Medicine is now making money rather than losing it as they did last year.

The Reference Committee wanted those two facts presented to you.

PRESIDENT HENDERSON: Dr. Savage, might we have the report of the Fiscal Agency, just a synopsis?

DR. F. J. SAVAGE (St. Paul): This report shows the carrying value of securities held by the Minneapolis Trust Company of the figure Dr. Locken gave you, $24,679.26. There has been, of course, a shrinkage in the market value of these securities as compared with the carrying value, but as compared with a good many

business concerns it is not great. It amounts to about 13.7 per cent, which I think speaks rather well for the type of investments which we have.

In addition to that, since the first of the year there has been one Northern States Power bond bought, and there is cash on hand of $437.55 up to May 15, which makes the net carrying value of the trust fund practically $25,000.

PRESIDENT HENDERSON: I am sure this report of the Fiscal Agency is very interesting. I think all of you would like to have the Fiscal Agency handle your affairs.

DR. JOHN M. ARMSTRONG (St. Paul): The report of the Treasurer was not sent to the delegates, and no report of this reserve fund was sent to the delegates. In the Treasurer's report which was handed us this morning it says it covers the period from December 31, 1931, to May 1, 1932. That is for four months only. I notice in the disbursements that some of the items cover twelve months. For instance, it has just been brought out that the Public Health Education Committee spent $1,383.89 in twelve months. This deficit for Minnesota Medicine of $1,726.26 covers twelve months.

It seems to me that gives a very erroneous idea of the finances of this Society, and I think the Treasurer's report should have been sent to the delegates. The report covering the period before this, before December 31, 1931, was never sent to the delegates at all, and this report covering the period from December 31, 1931, to May 1, 1932, was only handed to the delegates who came here this morning.

SECRETARY MEYERDING: I might explain for the bookkeeper. We have had the auditors, Shannon and Byers, for years, and they approved these figures. The annual report figures correspond as well as the others.

DR. ARMSTRONG: I don't question the figures at all. but I think it is very badly put. Here is a thing that covers four months in part of it and twelve months in another part. It may be correct; maybe the money was spent in those amounts up until this time, but it seems to me to be a very strange report.

SECRETARY MEYERDING: In our auditor's report the same figures exist for the twelve months.

DR. ARMSTRONG: I am not questioning the figures. I say it isn't the report.

SECRETARY MEYERDING: We go by the auditors. They tell us how to run the books.

DR. W. A. COVENTRY (Duluth): What item in the partial report as of May 1 covers it as of 1931?

DR. ARMSTRONG: The report just made by the Public Health Education Committee covers twelve months since the last meeting. It says at the top here four months.

DR. COVENTRY: That doesn't appear on my report, anything about twelve months here.

DR. ARMSTRONG: I just put it in because it was reported as twelve months.

DR. COVENTRY: Who reported it?

DR. ARMSTRONG: The Public Health Education Committee.

DR. COVENTRY: I think Dr. Armstrong probably misunderstood somebody's report that this amount of money was spent during the year.

DR. ARMSTRONG: I will call your attention to the deficit for the year 1931.

DR. COVENTRY: It says for the year 1931. It does not say anything about anything else.

DR. ARMSTRONG: Why take this here for just the four months? I don't doubt that the figures are correct. I am not saying anything about that, but I mention the fact that no report was given to the delegates until this morning.

SECRETARY MEYERDING: These reports did not come up before then.

DR. ARMSTRONG: They should.

SECRETARY MEYERDING: I agree with you. We have to pay the deficit after the first of the year. The deficit in Minnesota Medicine for 1931 was paid for in 1932. We can't pay it before it exists.

PRESIDENT HENDERSON: Is there any further discussion?

DR. COVENTRY: I move that the report of the Treasurer and the report of the Fiscal Agency Committee be accepted.

The motion was regularly seconded, put to a vote and carried.

PRESIDENT HENDERSON: Report of the American Medical Association Delegate. I will call on Dr. Wright.

DR. C. B. WRIGHT (Minneapolis): Mr. President and Members of the House of Delegates: We have had two meetings of the House of Delegates of the American Medical Association which have not been reported on. Dr. Braasch will discuss the Philadelphia meeting, and I will say a few things about the last meeting in New Orleans.

The thing I was particularly interested in, as you know, was veterans' legislation. The Philadelphia meeting passed a resolution advocating an insurance plan of benefits for veterans. That stirred up a good deal of interest.

The Board of Trustees appointed a committee on legislative activities and Dr. West and the Chairman of that Committee were asked to appoint an auxiliary committee on veterans' legislation. We had several meetings, one in Indianapolis with representatives of the Executive Committee of the American Legion, one in Chicago at which were present representatives from the Veterans' Administration, the Board of Trustees, both committees and the American Legion.

Then we had a follow up meeting in Washington on the first of February, and then we met before, or with, first the National Rehabilitation Committee consisting of, I understand, representatives from every state in the union, and presented our resolution. They did not approve our resolution. They did not feel that it was sane, rational or sound economics, and they were quite sure that Congress would never pass it. So at the meeting before the Medical Advisory Committee of the Veterans' Administration, we dispensed with the discussion of the resolution and went on to discuss various aspects of the whole situation. Finally a Liaison committee was appointed consisting of four members of the American Hospital Association, The American Legion and the American Medical Association.

There was nothing definitely settled, but we established friendly and cordial relationship with the American Legion. Mr. Cliff of Minnesota was one of the Committee. The interesting thing about it was that although at Detroit they had passed a resolution telling us in no uncertain terms that they did not care to have any suggestions from the American Medical Association on the care of veterans, at this meeting they solicitated our coöperation in the handling of this big problem, which the leaders in the American Legion, I think, are beginning to realize is tremendous and they are not satisfied with the workings of the Veterans' Administration. They would like our support and cooperation.

The government has made enormous investments in veterans care. It has taken on something which the world has never tried before.

In New Orleans we made a report of our Committee which was received with considerable enthusiasm. There were some interesting developments. First, it was the general opinion that any definite plan should be abandoned by the American Medical Association and that we should help the states organize as there were several plans already proposed by various state associations. We felt that we should work with the Amer-

ican Legion and coöperate with them, and give them our best advice and try to convince them that the veteran who has an acute surgical and medical condition particularly, cannot be properly and efficiently taken care of under any system of government red tape or veterans' hospitals, that these acute medical conditions must be taken care of through the regular channels established for the rest of the people, and that further hospital building for this purpose should be abandoned.

The medical man, who I think has the most influence in the American Legion, came to the New Orleans meeting soliciting our coöperation. His plea is that: First, the Veterans' Administrations is not handling the problem the way it should; that the Veterans' Administration is controlled by a layman who dominates the medical department. He even told us that Dr. Griffith, who is the Medical Director, has to call up Colonel Ijams before he can talk to General Hines, and if the Colonel is busy he must wait to talk to him before he can talk to General Hines about medical care.

The trouble is lay control of the medical care of veterans. He feels that the care of the service connected man should be emphasized. He claims that if we show our interest and coöperation, other problems of the non-service connected disabilities will iron themselves out.

Due to the fact that "hard times came in the middle of this depression" as Andy says, the meeting in New Orleans was poorly attended, but it was an excellent meeting. I think the papers were up to standard, as usual. Dr. Thayer gave a very interesting paper on medical education, which I think every medical educator ought to read with some care, because he made some suggestions about medical education, particularly secondary education in the United States which I think was exceedingly valuable and interesting.

The particularly interesting thing, as usual, was the scientific exhibit. Year after year it gets better. I was particularly struck with the beautiful, artistic work being done by the various exhibitors. Haydn had a very interesting exhibit on anemia, from the Cleveland Clinic, and, as usual, the Mayo Clinic had probably the most beautiful exhibit at the meeting. Dr. Dewey's and Dr. Bargen's exhibits of wax models on rectal conditions, operative procedures, and so forth, were really marvelous.

As far as the House of Delegates was concerned, except for veterans legislation, I think any one who attended the House of Delegates was impressed with the interest of the delegates, and the better attendance than a few years ago. When I first attended the House of Delegates, you could find delegates all through the sectional meetings and at various other places. They would come in to help elect the president, at the last minute.

At New Orleans, some 162 members sat through the meetings in a hot room and listened to reports with apparently a great deal of interest.

The reports were discussed very thoroughly and some of the reports aroused considerable comment and stirred up quite a bit of discussion. For instance, Dr. Brook of Michigan introduced a resolution and asked for a committee to study the subject of birth control. The House of Delegates took the stand that they didn't know what birth control was. They wanted to know what was meant by birth control, birth prevention or contraception. There seemed to be a rather general feeling that papers to explain the situation would be interesting; also scientific investigations of the whole situation to find out what is going on, but for the House of Delegates to come out and endorse at the present time, until it at least reaches some more scientific plane would be inadvisable.

As far as News Orleans was concerned, of course, its hospitality is proverbial. It was a little too hot for comfort. We wound up the meeting by electing Dr. Dean Lewis President of the American Medical Association, and designating Milwaukee as the place of the next meeting. The complete walk-away of Milwaukee for this meeting rather suggested to me they still had not forgotten the thing that made Milwaukee famous.

PRESIDENT HENDERSON: We would like to hear from the other delegate, Dr. Braasch.

DR. WILLIAM F. BRAASCH (Rochester): I am supposed to give a résumé of the transactions at the meeting held in Philadelphia in 1931. Before doing so, I would like to touch upon some of the interesting data which appeared in the report of the Board of Trustees for the years 1930 and 1931. These reports are printed annually in the Journal of the American Medical Association, giving opportunity for all members to read it. I am under the impression that very few members of this House of Delegates here assembled have read this report carefully. I fear there are but few of us who are familiar with all the work that is going on under the direction of the officials, the committees and bureaus of the American Medical Association, all of which are supposed to be under the guidance of the Board of Trustees.

It is quite remarkable how many ramifications there are in the field of economic medicine which are being carried on for the benefit of the physicians of the country. It is unfortunate that so few of them are familiar with all that is going on. I am sure if they were, they would feel they were getting a great deal for the nominal sum being paid for dues to the American Medical Association.

I wish there was some method whereby the most important features of the work could be headlined in some way and brought home to the casual reader. It would certainly be a wonderful thing for the American Medical Association and I believe it could be done. We have the monthly bulletin, it is true, which has made a great advance in carrying home the activities carried on, and making us familiar with the work, but at the same time it is more or less in a casual and routine way. I think it would be worth while if some of the more important features of the work carried on by the Association were featured at intervals in the Journal of the American Medical Association.

It is superfluous for me to say that the Journal today stands unquestionably as the outstanding medical journal in the world, and is so recognized by all observers.

Among the other publications supervised by the genial editor of the Journal, who is with us today, particular mention should be given to Hygeia. The continuous progress made by this journal should be a source of tremendous satisfaction to us all. It has undoubtedly been of great help to medicine. This publication is certainly to be congratulated on the fact that it is being read by such a wide circle of laymen. We should further its circulation in every way possible. I know the Women's Auxiliary has done much in this respect, and we medical men should do more to see that it is read by our patients.

I don't know how many of you are interested in the Quarterly Cumulative Index Medicus, but when anybody writes a paper the first thing he does is to turn to the Cumulative Index Medicus for his references. As you know, the Carnegie Foundation has helped to publish the Index Medicus in the past. However, they have given up their support and have placed the onus of its publication upon the officials of the American Medical Association, who have taken it up, and will continue the publication which is so essential to scientific medicine. Certainly, in assuming this responsibility, the Association is fulfilling a great benefaction upon the future of scientific medicine.

The Coöperative Medical Advertising Bureau is an-

other item that perhaps might have escaped your notice, which I think is very important as a development in medical journalism. We are informed that there are but thirty-one state journals represented in this bureau. There is no adequate reason why every journal sponsored by a state medical association should not be included in this list. The work of this bureau is unquestionably of aid in raising the character of many medical journals. In some cases it makes the publication of state journals possible, and incidentally it serves to eliminate unethical journals in this field. That alone is an industry or activity which is well worth while and should be acknowledged.

Let us not forget the American Medical Directory which is published every other year. I dare say many of you have found this to be an invaluable aid. While there are some features open to criticism, on the whole it is certainly a very valuable publication. There is at present a movement on foot to definitely standardize the various medical specialties. It is being proposed that before anyone can practice a specialty he must pass an examination given by some recognized national society in the specialty. If a list of those so recognized could be published in the directory at some future date, it might be of great value to us.

The Library.—Your committee would especially recommend the continued development of the package library service which was increased during the year some 20 per cent. This has been of tremendous help, particularly to those who live away from the centers and don't have access to the large medical libraries that we have, for instance, in the Twin Cities. It has increased in the past year some twenty per cent, which shows its importance and how much it has been appreciated. It makes available a wide range of material ordinarily unobtainable in outlying districts. This, together with the correspondence regarding references, is a most important service of the Association.

I can't speak too highly of the work of the Council on Pharmacy and Chemistry. This most important council is increasing from year to year and is a tremendous factor for the advancement of modern medicine. Together with its subsidiary, the chemical laboratory, they are doing a most important piece of work in establishing the high standard of therapy set by our Association. We would especially commend the Journal for its action in giving full publicity to the investigations of this council.

I don't know whether you fully appreciate the importance of the Committee on Foods. The work has just been started in the last year or two, and it has been given an independent status lately because of its importance. While it may be too early to pass judgment as to the final value of this work, nevertheless it would seem that what they have already accomplished is of a distinctly constructive nature. If it can influence and correct any untruthful statements made in advertisng foods, it will be of great value to the public. If it can be of help in giving the profession a better idea of the value of certain nutritional facts, it will also be worth while. There have been some criticisms made of the methods employed, but I think the faults have been corrected in the past year.

The Bureau of Health and Public Instruction is also doing good work in its efforts to stimulate the interest of the laity in medical problems, and this should be furthered in every legitimate way. The influence of the radio seems to be increasing apace. Those of us who are forced to listen to the so-called health messages given out by Dr. Brinkley and men of this type naturally resent their blatant audacity. We understand that efforts have been made by the Association to overcome this, and it apparently is a very difficult problem to solve.

The Bureau of Legal Medicine and Legislation, handled by Dr. Woodward, has been of great value, as you all know, keeping us in touch with legislative progress, and also helping us solve the various legislative problems.

The Bureau of Economics was established at the Philadelphia meeting by the House of Delegates. Work has been done along that line previously, it is true, but it had not been carried on in an organized manner. During the past year a creditable amount of work has been done. Those of you who have read the report of this year have probably been surprised at the wide scope of subjects outlined for the future activities of the bureau. A point has been made, however, that future activities of the bureau might be concentrated so as to find a solution of a few of the most urgent problems confronting the medical profession. We could well afford to make an increase of expenditure in attempting to find the solution of many of the problems which are of most vital importance to us.

On the matter of income and expenditure, according to the auditor's report the American Medical Association is adding to its surplus gradually by wise methods, and this has now reached a very considerable figure. Comment was made in the last meeting of the House of Delegates that we might use some of the surplus money in the treasury to further certain activities essential to the progress of organized medicine. In other words, while future accumulations should be safeguarded in every way, we could use the surplus money for some of the purposes I have mentioned.

You will pardon me for going into detail on these various questions, but I am sure they are of greatest importance to all of you who are interested in organized medicine.

PRESIDENT HENDERSON: These are very important questions. We only wish we had more time to take them up and discuss them. We would like to hear from Dr. Johnson.

DR. H. M. JOHNSON (Dawson): Mr. President and members of the House of Delegates: Reports on these various meetings have been given very completely, and there isn't much to add to them. However, I want to say this: that the American Medical Association is a wonderfully big giant of an organization. There is power there. It is hard to comprehend until they use the direct methods necessary to protect our profession. I think the Legion, for one thing, is not the last one to realize that when the American Medical Association really takes hold of things and means business there is a time that they had better listen and consult with them, rather than be against them.

As far as the work of the American Medical Association is concerned, it is very extensive in many ways, and is wonderful. I think in one way we might say it has entered somewhat of a new era. Before it has been mostly scientific. Now it is beginning to be a little more economic, and probably more directly active in legislative affairs. You have a wonderful Bureau of Legal Medicine and Dr. Woodward is one of the finest men you can ever find, but he needs help. There is no man who doesn't need help in these days. I think this committee has been a wonderful asset for his bureau.

I want to say to you that the Legislative Committee of the American Medical Association has done wonderful work in contacting the Legion and are going along on right principles. At first, the Legion wouldn't talk to the American Medical Association. Now they do talk to them and talk nicely. They want to talk to them again. I think it is a fine thing that the two organizations are getting together.

The American Medical Association is also tackling the economic problem and are backing up the Legion's legislation. That started in Philadelphia. In this last session the A. M. A. was more forward looking along that line than ever before, and I feel great progress

has been made. It isn't just one state. It has to be all states, and we all have to work under one head, which is the great American Medical Association. I think we have every reason to be proud of it.

PRESIDENT HENDERSON: Dr. Stewart, are there any more credentials to be presented?

DR. A. B. STEWART (Owatonna): Before making a supplementary report, may I ask if any delegates here have not handed in their credentials.

There have been tihrty-five credentials handed in. The Secretary has vouched for two, and I think there are three more in the audience, which will make forty delegates present.

PRESIDENT HENDERSON: The next order of business is the report of the Editorial Association Committee. Is Doctor Larsen here?

DR. O. O. LARSEN (Detroit Lakes): Dr. Watson is chairman of this Editorial Association Comimttee. In his absence he asked me to report. I shall read his report first. However, I wish to state we have had two meetings this year.

Dr. Larsen read the report submitted by Dr. J. A. Watson.

REPORT OF COMMITTEE TO COÖPERATE WITH THE MINNESOTA EDITORIAL ASSOCIATION

It becomes more evident as time goes on that this committee has a useful function to perform. Throughout the year we have been in close touch with the Minnesota Editorial Association through the committee of that association, which has been appointed to confer with the State Medical Society.

Progress has been made in the direction of clearing away many of the misunderstandings which have in the past existed between the two professions and a foundation has been laid for work that will undoubtedly be beneficial to both. Mr. Benshoof, chairman of the editorial committee, has been exceedingly active in endeavoring to outline a plan whereby some form of concerted advertising, which would not be objectionabel from the standpoint of medical ethics, might be undertaken with a view to the benefit not only of publishers and doctors alike, but more specially the benefit of the public at large. There is certainly nothing in the code of ethics which forbids such advertising, though it is true that the ideas of the doctors and of the editors do not yet entirely coincide on this matter.

Your chairman has had many conferences with Mr. Benshoof and the members of both committees and has attended nearly all of the meetings of the chairmen of the various committees of the State Medical Association and also the county secretaries meeting.

J. A. WATSON, *Chairman.*

DR. O. O. LARSEN: This is the report I have seen fit to give with the help of Mr. Benshoof.

Dr. Larsen read his report.

REPORT OF EDITORIAL ASSOCIATION COMMITTEE

During the past year your Committee on the Joint Advisory Board of Public Relations with the Minnesota Editorial Association has maintained contact and had a conference with the Press group on January 22, 1932.

At this conference the suggestions as made by the Press group were unanimously adopted and they were asked to prepare and present in some specific form concrete examples of the form of ethical advertising or publicity in which they felt the medical profession might engage for the dissemination of authenticated scientific facts regarding the treatment of physical ills, and thus assist in making the great mass of newspaper readers medically-minded in favor of the legitimate practitioner rather than the quack and imposter.

Mr. Roy L. Dunlap, managing editor of the St. Paul Pioneer Press-Dispatch, a member of the Press group, is here to present these sample layouts and to explain in detail his viewpoint of how organized medicine will be benefited, directly and indirectly.

Your committee is of the opinion that there is a decided change in the viewpoint of many members of our organizations relative to the proposal of having a somewhat closer contact with the Press than has been the case in past years. Such a contact will, we are convinced, be beneficial to both Medicine and the Press in the better understanding which will result and the possibilities of mutual gain for both organizations as a whole.

As a matter of fact, various groups of organized medicine have, during the past two years, engaged in a campaign of paid advertising in the newspapers with excellent results. This is shown by a national survey now under way by a committee of the Illinois Medical Society, headed by Dr. J. H. Hutton, past president of the Chicago Medical Society. Another survey is being undertaken by the Julius Rosenwald Fund, of Chicago and New York.

On February 25, 1932, a conference was held at Chicago by the committee working in Illinois and representatives of the daily newspapers of that city—the first conference of its kind ever held in either the city or the state. This followed a similar conference with representatives of the large advertising agencies in the same city.

At that conference it was suggested that the following problems might be included as among the things which members of the medical profession desired to convey to "the man on the street": (1) People ignore physical danger signals; (2) The doctor is frequently called in too late; (3) People are delaying calling the doctor because of economic depression, and are not aware of the medical treatment available to them at little cost in the average community; (4) The public needs to be educated on the subject of regular health examinations by the family physicians; (5) The public needs to be educated to avoid self-medication; (6) The public needs to be given some enlightenment in the matter of economics and the idea that the doctor is the last person to be paid; (7) Advertising, coupled with news story and lectures, would become a powerful factor in eliminating the medicinal impostor, quack and charlatan.

In New York, the Committee on Health Examination, in the name of the organized medical profession of Greater New York, conducted an extensive campaign in 1931, established the fact that valid, ethical, paid advertising could be carried on without in any way relaxing the constraint imposed upon the individual physician. The campaign was pronounced universally successful, brought additional patronage directly to the doctors within the area covered, and the cost was very moderate. The effects of the campaign will be noticeable for a long period in the future.

The Winnebago Medical Society, of Rockford, Illinois, conducted an immunization campaign, using chiefly paid newspaper space, and attained outstanding results. Similar campaigns are reported from (not necessarily covering immunization, but of a more general character) the states of Iowa, California, Washington, New Jersey, North Carolina, Ohio, Kansas, Texas, Wisconsin and West Virginia. Results from these varied according to the attention given them, text matter used, period of time covered, amount of money expended, etc.

Several of these states used a series of articles prepared and sold by a Wisconsin publicity expert, but it was agreed that these were too general in type to be applicable in many localities, and this could and should be overcome through a direct contact with newspaper publishers familiar with the conditions to be met in any given area to be covered.

The observations of Mr. Ernest Elmo Calkins, dean of the advertising world, located at Detroit, Michigan, may be worthy of quotation here:

> The advertising that doctors do must be unselfish, devoted entirely to the value and importance of health and the means of preserving it, and especially the necessity of having a family doctor to consult with, and his importance in the scheme of things.

The Committee of the Illinois Medical Society, in summarizing their research survey, has this to say:

> The final important consideration to be set down here is that it has been proven advertising can be conducted for the medical profession on a strictly ethical plane and with successful results where it employs proper advertising technic.

Minnesota has the distinction of being the first state in the Union to establish a direct and permanent contact with organized medicine and organized newspapers, and it is quite likely that this movement and method will be adopted in other states.

Your committee has found this contact both pleasant and profitable and recomemnd further conferences which cannot but be otherwise than mutually beneficial —and profitable.

We also recommend that the most serious consideration be given the proposals of the Press representative appearing before you with his sample layouts explaining how paid advertising may be used by organized medicine in an ethical, dignified and profitable manner.

O. O. LARSEN, M.D.

PRESIDENT HENDERSON: The Reference Committee, Dr. Collins.

DR. A. N. COLLINS (Duluth): The report of the Editorial Association Committee is very interesting indeed. The report of the Editorial Association Committee as made by its chairman, who was absent, and by Dr. Larsen, who has just reported to you, outlines the work of the committee during the past year. It recommends that serious consideration be given to the proposition of the press representative who will appear before you with his sample layouts to demonstrate how advertising may be used in an ethical, dignified and profitable manner.

PRESIDENT HENDERSON: We have pleasure in having with us today Mr. Roy Dunlap, managing editor of the St. Paul Dispatch, who has agreed to talk to us for fifteen minutes. We will be very pleased to hear from you, sir.

MR. ROY DUNLAP: Mr. Chairman and gentlemen of the House of Delegates: I am not going to take the fifteen minutes because I know you are busy and what I have to say can be said very briefly.

A great many of you are familiar, of course, with what the Editorial Association Committee, of which I have the honor to be a member, and your Medical Committee have been doing in the past year and a half to work out the problem of a better contact presenting the side of medicine in a legitimate, authoritative way.

It is not necessary to tell you that the newspaper is second to none in its zeal to safeguard the public. Our prime function, of course, is to give information. When we get that information we want to be able to swear that the information about medical subjects is true; we cannot hope to do that without the cooperation of the members of the medical society.

I believe the doctors and the newspaper men are very poor business men, and rightfuly so. The doctor has his scientific mind which he must develop and follow, and he hasn't time to pay attention to some of the sordid details of the commercial world. The same is true of the editorial department of the paper which I happen to represent. We are taken up with giving facts and figures, data to the public in the shape of authentic news, as authentic as possible, so we haven't time. We leave it to our business managers, because it is a proposition of revenue.

What I am trying to explain is this: I am not here to make a selling talk for any advertising program. I couldn't do it if I wanted to. I know nothing about it, but I do know that the public is being preyed upon from a great many sources which you and I can stop if we will only get together.

In the last few years there has grown up a method of public information dissemination which is in its swaddling clothes, and which has not yet learned its lesson of responsibility to the public. I speak of the radio broadcast. It makes me very tired to sit at home with the radio on in the evening and hear some of the most terrible information broadcast in the name of science and medicine. It made my blood boil one night to hear a station broadcast from Mexico on the treatment of spinal meningitis in South Dakota. We propose to meet with you gentlemen in a campaign to stop that sort of thing.

This campaign was designed on two lines: (1) To educate the public to pay the doctor; the doctor is worthy of his hire; (2) to educate the public to call the doctor. I have brought with me some sample layouts because pictures speak louder than words.

(Picture) I am going to leave this in Dr. Meyerding's care as long as I have explained them briefly to you.

Here is one along the line of calling the doctor.

Here is a man who says, "I guess it is the mumps."

Here is one discussing anemia. These are put up merely as samples to tell you what the two committees have been working on.

Those two dealt with the question of health. Here is one that deals with the doctor's job. Here is a picture of a man standing in front of the doctor's office in a thoughtful mood, and the question is, "What about the next time?"

I am not going to read all of these, gentlemen. I am not going to take up the time. I am going to leave them in Dr. Meyerding's good care, and I am sure they will be here for your inspection or in the exhibit hall.

There are just one or two things I want to emphasize in this program. First, I want to thank the doctors who represented your committee. They worked well under the tutelage of Dr. Watson. We have had frequent meetings and they have been excellent meetings. There has been a minimum of dispute and we have worked in a real coöperative spirit that gave us courage to go on and present this program. I want to thank you also at this time for the privilege of appearing before you to tell you briefly what we have done.

I want to emphasize that this program must be done in a cohesive manner. It must be done with the coöperation of the medical men. If this program is adopted and these advertisements appear in newspapers, we want to know that the subject matter has been O. K.'d by the physicians themselves, or any committee they suggest before they see the light of day. That will attest to their authenticity.

The second is that I would like to suggest that program if adopted, be presented in a group of state newspapers, and not in one little section, county, or district. That may be done later. After the state campaign has been made, they can be carried down to the smallest home through the medium of the local newspapers. That could be done by the district or the county.

This is not going to cost anybody a great deal of money. I think it should be put on through assessments, perhaps, and I am sure you will find the rate will be very low because we are willing to go our share of the way to help you present this case.

There has been an attempt made in some sections of the state, I believe, to rather anticipate a campiagn

by running a local series of advertisements. All very well and good. We welcome that as evidence of earnestness in the soundness of our position, but I believe the best benefits are going to be had if this is done by your body as a whole and by our group as a whole. That is the feature which I would like to leave with you, that this should be done by the State Association in a selected list of newspapers, and if it is going to be carried on in localities it will be done after it has appeared in a statewide or large way.

I do not need to tell you of the value of advertising, how the citrus growers, for instance, put themselves on the map. I do not want you to expect, if this series of advertising is run, that you are going to see results tomorrow, the next day, or next week. You probably will not see them for months to come, for the history of advertising teaches that the results are not going to come the instant of exposure. It is like the constant dripping of water on a stone, the constant wearing away, which will bring about education of the public.

The newspaper which does not perform its function of educating the public is not a newspaper in the true sense of the word. We cannot hope to present medical education without your assistance. We in St. Paul have been very fortunate. This question was thrashed out some years ago, and the Ramsey County Medical Society appointed a committee to work with the newspapers, with the result that when anything new bobs up in the way of a supposed cure, we immediately refer it to the doctor's committee, and are able to print it with a note of caution from the doctors that this thing is rather new, and we had better wait until it is further developed and further experiments have been made before we accept it. We all know that the man who is ill and in desperate straits, is a drowning man grasping at a straw when a new cure appears.

I am going to leave these advertisements with you. I want you to study them. I want you to know they are done in the most dignified manner. There is nothing there that is going to in any way cross the doctor's code of ethics. There is nothing in there that you would be ashamed to have appear in your local newspapers, because the whole idea is educating along two lines: Guard your health, call the doctor when you are ill, and pay the doctor, and I am sure if this campaign is run in that way, in due time you will see it will have a wonderful result.

Gentlemen, I thank you.

PRESIDENT HENDERSON: We will arrange to have these posters in the State Association booth downstairs so if any of you wish to look them over you can do so at your leisure.

We have with us this morning our genial Dr. Fishbein, and we would very much like to hear from him, if he could give us some information.

DR. MORRIS FISHBEIN: Since the subject of advertising by the medical profession has been introduced, I might just as well talk a few minutes on that subject, since I will have an article on the subject in the next issue of the bulletin of the American Medical Association. I discussed the subject before the New England Medical Council in Boston about two months ago, and I discussed the same subject at the meeting of the Chicago Medical Society on economics about three weeks ago.

There is a whole lot more to advertising than just buying some space in a newspaper and developing an educational message. I may first of all agree absolutely with the editor of the St. Paul Dispatch that it is the duty of the newspaper to educate the public on health just as much as it is its duty to educate the public on bridge, etiquette, cooking, and various similar topics. I noticed evidence in the Pioneer Press this morning of some attempt to educate the public on the subject of health, unfortunately educating them entirely wrongly, and by a man who is wrong about ninety per cent of the time, namely, Dr. William Brady.

In the Pioneer Press Dr. Brady tells the public that the ambulatory treatment of hernia by injection is the proper method, and he also says that the right way to remove tonsils is by electric coagulation. I presume your message will appear on the opposite side of Dr. Brady's article, so the public may take its choice. He is being paid for it by the paper, and the paper is paid for by the buyers. That is an unfortunate situation, but it occurs not only in the Pioneer Press but in other newspapers. There are men writing health education sentiments in newspapers that are not sound, and newspapers have learned always to buy material on the quality of the writing and on the perhaps sensational manner of the exposition rather than on the basis of scientific accuracy.

As to buying space in newspapers, that is not entirely a new idea. In 1927 a state association, through the individual county societies, spent approximately $75,000 raised by special assessments in order to buy space in newspapers. If I had my lantern slides here I would throw them on the screen and you would see the same ads that have just been shown to you, practically the same type of advertisement that has been shown to you today. I may say that the advertisements and the entire campaign were not only without success, but really had an unfavorable reaction on the medical profession, because every time the medical societies bought a quarter of a page, the chiropractors bought two pages and the osteopaths bought a page or two. Each day after the medical advertisement there would appear a competitive ad by the chiropractors and osteopaths. The medical society tired of the drain after six months, and the advertising campaign was discontinued, representing not only a total loss but worse than a total loss. They had to overcome prejudice that was raised by entering into controversy with men who could not be considered their scientific equals in any way.

It is the duty of newspapers to educate the public on health, but people who best know how to write material on health are physicians, and the authoritative group of physicians is the state medical association.

In the state of Indiana the state medical association issues material to newspapers on health, and the newspapers not only run it without charge, but feature it on their editorial pages. In Wisconsin the same thing is done. In Michigan the same thing is done. In addition to that, we all know space is being bought today to educate the public on health in magazines, and may eventually come to newspapers, by the great manufacturing houses that coöperate with scientific medicine, and which depend on the good will of scientific medicine for their support.

The Metropolitan Life Insurance Company spends four million dollars a year in health education, and I may say it is sound health education carried out under Dr. Armstrong. Practically all of that material is sound. The Parke-Davis Company spends $250,000 a year for purely educational copy which is run in the Saturday Evening Post, Ladies' Home Journal, Literary Digest and Time. Squibb and Company spends approximately $200,000 and Eastman Kodak Company approximately $1,000,000 a year on health education along this line. You have all seen these advertisements.

You have heard Logan on the radio Sunday night, and the great series put out by Squibb over the radio. Money is being spent in sums so great that anything you might put before the public would be merely a drop in the bucket. There would also be the added possibility of having your motives misunderstood, and of having opposition groups, the cultists and quacks, entering into competition with you.

In Rockford, Illinois, where I spoke, the doctors of the community advertise in the newspapers not only as

a society but individually. Many of the doctors of the community, possibly forty of them, put their cards in the newspaper every day, with their names, office address, hours, telephone number, and specialty, if any. They got into a great deal of difficulty. The osteopaths, chiropractors, naturopaths, and physico-mechanics of various types began inserting ads which were intermingled with those of the doctors in alphabetical order. They said to the newspaper, "You induced us to enter this educational campaign. What is the idea of mixing us in with the charlatans?"

"You said you were out for education of the public."

So there were two tables, one headed "Physicians," and the other table headed, "Other physicians." So here are the doctors on this side, physicians, and on the other side of the page, other physicians.

Quite recently the Hudson County Medical Society bought themselves a page in the newspaper in Passaic, New Jersey, and in surrounding newspapers. They took an entire page to print the names and addresses of all the doctors in the county medical society, and then they had put in every physician's office a certificate hung on the wall indicating he was a member of the county medical society. That ad ran once and, as far as I know, nothing has come of it, and probably nothing ever will.

The classified telephone directory tells the public the same thing. If they want to know where a doctor is, they look in the classified directory. They may be mixed up with osteopaths and chiropractors, but if people have any luck they may get a good doctor. If they get a good one, they will keep him, and if they get a bad one, they will discontinue going to him. Advertising of physicians is impossible because it places a premium on the man who can spend the most money, and he is usually the charlatan because he gets his practice through money and not through his scientific accomplishments.

Collective advertising by a state medical society to educate the public in health is unwarranted because it is the duty of the schools of the United States, first of all, to educate the public in health, and they are doing that in increasing measure through coöperation with a committee of the American Medical Association and the National Education Committee. Health is now placed first among all subjects to be taught in elementary and high schools in the United States, and children today are learning about their bodies, and learning what a good physician is. If you will look at the textbooks of biology and physiology in the schools, they are learning how to tell the difference between a quack and a good doctor. That is the place to begin educating about health, in the grade schools and then in the high schools, and not in the newspapers.

The next point about educational health is that newspapers must educate the public regarding health if they are going to be good newspapers. The gentleman who preceded me has told you that when a new medical discovery is made the newspaper has to put it on the front page or it isn't news. They have to say, "Liver extract is found to be valuable in the treatment of pernicious anemia." That is what the people want to know. We needn't worry about the newspapers paying attention to news in the field of scientific medicine.

On the question of educating people to pay their doctor, it is quite conceivable that they can be educated to pay their doctor. I feel that the dignity of medicine and the science of medicine is such that we are in a bad position by going out and buying space to educate the public to pay for service which, if they get good service, they are glad to pay for. Doctors have their percentage of uncollectible bills, which is probably larger than for other services. Department stores don't have it because they stop credit.

If the doctors will study their own economic situation, will study methods of collection, methods of extending credit, and methods of handling their own work in a serious, scientific and business-like manner, extending credit to those who require it, taking care of the poor and those unable to pay, really putting their profession on a scientific, business-like basis, they will find they can reduce their losses and increase their ability to collect just the same as any other business.

I don't know how much money you people have to spend on this kind of ads or whether you want to assess your individual membership to buy them. I hope you will all read the article which will come out in the bulletin of the American Medical Association, which constitutes a survey of this entire experience over a period of five or ten years. I hope you will study the matter much further and give it real scientific study before you adopt it, rather than being swayed by the impulse of the moment, which is that in a time of depression we try everything possible in the hope that business will improve. Then when business does improve in the ordinary course of events, you are likely to say "It was the last measure that brought it about," just exactly as you say that it was the last drug that went down the patient's throat that brought about the cure, which may have come about in the natural course of the disease.

PRESIDENT HENDERSON: Thank you, Dr. Fishbein. Is there any further discussion?

DR. C. B. WRIGHT (Minneapolis): I agree with much that Dr. Fishbein says, but I don't believe he intended to give the impression that local societies should take no interest in this subject.

It is true that certain societies have locally put on campaigns which they think have done some good. We know that doctors in the smaller towns buy space in the newspaper. Perhaps they could use the money spent to better advantage.

I would like Dr. Locken to tell us about the publicity campaign in his society.

DR. O. E. LOCKEN (Crookston): It would take a great deal of courage for any man to stand up here and offer an opinion contrary to the brilliant mind of Dr. Fishbein.

We people went into this matter this spring, and it was a question of whether we should do something positive about the economic situation. We are not attempting to advertise to the people on the science of medicine, but we are trying to do something in regard to changing their opinion about paying the doctor.

For the first ten years, most of us are very flattered in having patients come to us, and some of us thought for a long time that these patients were coming to us because of our own brilliance. After we had about $100,000 on our books, we began to think possibly they came to us because it was pretty good service that cost them very little.

So we are beginning to change our attitude just a little. We are now running a series of advertisements in the paper of Crookston that is paid by the two clinic groups in that town. We are advancing some information in regard to present medicine. The first advertisement, for instance, stated that the doctor is not only giving you his time and his judgment, but he is giving you something that costs money when he gives you an examination, because he is using scientific instruments that cost a good deal of money, and for that reason he has to expect that you pay for that service. The advertisement which came out last week said, "You should add a sixth item to your budget." To the necessity of budgeting groceries, taxes, and so on down the list of fundamentals, that they should add something to their budget for medical attention.

The first advertisement that came out did state that these two organizations were sponsoring this advertise-

ment in order to protect the rest of the doctors in the community who do not want to spend any money for it. We had this matter before the local organization in the town. We presented it to the Red River Valley Medical Society. They could see no objection to it, and said it helped others as well as themselves.

We had very interesting reactions. I had a woman say, "You didn't send me a bill. I called you out at three o'clock in the morning. I know you people are entitled to your money." We have had men write in and say, "I have noticed your advertising, which is O.K. with me," and send in their check. People in our community are getting to feel, when you have given your service, "How much will the charge be?" They go into the business angle more than they have in the past.

It is done in a purely dignified manner. I find when I am through talking to people I don't feel I have to apologize when I ask them to go into the business office and hand them the bill. I used to. I felt as a dignified physician I should only talk to them on scientific matters. I found that when my own psychology changed it was easier to talk to the people about that. I feel sincerely that there is a better relation between my patients and myself now than there was a year ago when I hardly dared mention the subject of money to them. We have a finer relationship between the patient and the doctor.

Out in the country we are getting to have the reaction that the specialists in the city have. When the people come in they expect to pay, and have a very high respect for our services.

We have only been running this a short time. This is purely a sample effort over a period of three months. There is just another side of it which I think ought to be mentioned. Every week a lot of information has been sent out by the Minnesota State Medical Association to all the newspapers in the state and our editor has thrown every one of those in the waste basket every week for the last three or four years. We have talked to him about it. He said, "Why should I be interested in your organization when you are not interested in mine?" We feel we can go to him (he is a good friend of ours), because we have spent a little money with him and expect him to put in this legitimate information which the state medical society is sending out, and he will. I know he will because the bankers of that territory said they would buy no more printing material from him if he continued to publish on the front page every time a bank closed in that territory. For two years there has never been an item in the Crookston paper that any bank had closed. These men understand economics, and we propose to talk to them in the language they can understand.

DR. MORRIS FISHBEIN: I would like to say that of course I have been quite misunderstood by Dr. Wright and Dr. Locken. I did not say it was unethical to advertise. It has already been established that it is quite ethical to buy advertising space, and any county or medical society can make its own decision. There are many communities in which individual physicians can advertise. That is considered ethical. There is no question about the ethics of the situation at all. This is merely a matter of business and psychology.

You have to decide whether or not it pays you to carry advertisements to have patients pay their bills because once you start to carry the advertisements you are going to have to carry them on and on and on, as they say, into the night, because here is an editor who doesn't print anything about medicine, who doesn't print the releases of the state medical society unless he gets an ad. He doesn't print anything about banks failing now because the bankers have brought a little pressure to bear on him. Once you get yourself into the situation where the knife is at your throat, the knife remains at your throat.

There are many good newspapers in the United States that constantly carry all the items sent to them by the state medical societies in those particular states, in Indiana, Wisconsin, Michigan, and a great many of the papers in Illinois. They are glad to print the material because it is well written, educational material, and if they had to buy it from the society they would buy it from the society. They do in Toledo, Ohio. In Toledo the newspaper buys the releases from the Toledo Academy of Medicine and pays for them, because they want that kind of material.

Advertising should not be indulged in extensively unless it pays, and it has to pay in proportion. You have to find out whether the cost of what you put into the ad is coming back in increased collections, or in a changing point of view. Then you have to measure what is already being done, and avoid duplicate coverage. When the Metropolitan Life, Squibb, Eastman, and others are spending six or eight million dollars a year in this type of advertising, you have to count where your $20,000 or $25,000 is going. Or you may be able to take $200,000 out of your membership, I don't know; I doubt it. But I imagine you might be able to do that for an advertising campaign. It will take a great deal. I am not sure you are going to spend your money for advertising and get it back in this particular way, but my survey of what has been done before causes me to doubt it extremely.

DR. C. B. WRIGHT (Minneapolis): I would like to ask Dr. Fishbein what he thinks of a plan for publicity through savings banks on saving for sickness.

Another thing: I would like to ask Dr. Locken specifically what this service is costing them in Crookston.

DR. O. E. LOCKEN (Crookston): We are paying for what they call quarter page advertising. I don't know how many square inches that is, but we are paying $175 for twelve of them. There are nine doctors paying for this, and it costs us less than $2 a week apiece. We collect one bill.

I see Dr. Norman is here. He is another man helping to pay for this, and I think has as much of a positive opinion as I have.

DR. MORRIS FISHBEIN: Answering the question specifically, I very much favor the idea of educating the public to save for sickness as they do for death, to get them to realize that sickness is inevitable and that they must save for sickness as they now save for an anticipated death.

In Worcester, Massachusetts, the plan has been put on in a big way, a local bank coöperating. In this case the bank buys the advertising, not the medical profession. The bank buys the advertising because the banker feels it is a good selling point for savings accounts in his particular bank. They have not only bought advertising space in the newspapers but have developed a direct-by-mail campaign to the individual residents of the community, and sent pamphlets direct by mail. Of course that is another point.

When you come to consider the question of education through advertising, you must remember that there is not only advertising in newspapers but advertising on the radio, direct-by-mail, advertising through pamphlets given directly to your patients by yourselves when they come in, which is the quickest and most direct way of reaching your patients that you want to reach. If the patients don't pay you, it is possible to develop literature that you can hand them, or send to their homes, that will tell them more than you can in the newspaper.

Bear in mind, I have not said you should not go into this scheme. I have not said Dr. Locken's scheme is not perfect for his town. I merely said that, so far as I know, no state has ever yet been successful with the kind of campaign proposed here as a state-wide

measure. That is the experience thus far. In Minnesota it might work, because all sorts of things happen in Minnesota.

DR. J. F. NORMAN (Crookston): Mr. President and Gentlemen: Dr. Locken undoubtedly has stirred up something here as well as in Crookston because, as he intimated at the beginning of his talk, we were not all in favor of his scheme to begin with. I think we all had the feeling it was rather unethical and undignified to go ahead advertising in any manner.

However, this series of ads has been run, and it is rather early yet to express our reaction toward it, but as Dr. Locken said, I think it is going to be favorable. People have been educated through many health agencies to believe they should get service for nothing. They will come in and have a rather elaborate examination, and you tell them there is really nothing needed in the line of medical treatment but you give them advice. They will ask you if there is any charge for the examination, because they have not received a prescription. We are hoping to educate them away from the feeling that the doctor need not be paid for his services, but are trying to have them understand that we expect to be paid for our work. That might not be dignified, but I believe the reaction in Crookston and in the Red River Valley will be favorable.

PRESIDENT HENDERSON: Mr. Dunlap, would you like to add anything?

MR. DUNLAP: I would like to suggest that inasmuch as Dr. Fishbein has a rival column with Dr. Brady, that would make him an incompetent witness.

We have merely tried, gentlemen, to offer something in the way of coöperation to beat back the racketeer and the charlatan in this thing. He is getting a foothold; there is no question about it. The doctors come to the newspapers and say, "You are putting in this sort of tripe in the way of medical advertisements. Throw it out of your paper."

The editor says, "I will throw it out. What will you give me in its place?" They shrug their shoulders and say, "That is your business and not ours." The editor is expected to give up that revenue. We all know we can't be in business for our health in this day and age. As I say, we didn't have any idea of precipitating a riot or a large sized controversy. It has been very interesting and I have enjoyed it very much. Thank you.

PRESIDENT HENDERSON: You have all heard the report of the Editorial Association Committee. Is there any motion to adopt?

DR. W. A. COVENTRY (Duluth): I move the report be adopted.

DR. H. M. WORKMAN (Tracy): I second the motion.

The motion was put to vote and carried.

PRESIDENT HENDERSON: Report of the Committee on State Health Relations.

DR. T. H. SWEETSER (Minneapolis): I do not like to read this whole report; there were just two subjects that were taken up, principally, during the year, in which I think you would be interested. One of them is medical care of the poor, and the other is the medical care of veterans.

The subject of medical care of the poor was rather revived by a letter from Dr. Adams of Bird Island, and Dr. Meyerding helped us arrange a symposium on the subject at the Secretaries' Conference in January. It was a very interesting symposium with talks by men from different states, and a final talk by Attorney General Benson on the legal aspects. I would like to mention the discussions by Dr. Scofield and by Dr. Herman Johnson. The experiences in Lac Qui Parle County seem to have been very successful; there is a definite arrangement there between the County Commissioners and the doctors. Recently Kandiyohi-Swift County Society appointed a committee with Dr. Branton of Willmar as chairman. They raised some questions as to conflicts between the extracts from the law that we published in MINNESOTA MEDICINE and the opinion of the Assistant Attorney General. I have spent considerable time at the Attorney General's office since that, and I think that there is no conflict unless in the understanding of the terminology of the law. At our meeting last night we decided to have copies of the different contracts and agreements between doctors and county commissioners in different counties in Minnesota sent out to the members of our committee through the state, and then an opinion, if we can get one, from the Attorney General as to the legality of these different agreements so that when questions are raised, you can get some direct information from the members of the committee in your own districts.

A minor matter has come up recently, and that is with regard to having medical representatives on the county child welfare boards, and we are going to get in touch with the Board of Control and the different child welfare boards and see if this can be done, or whether it is advisable.

We have discussed the care of veterans rather extensively, and have drawn up a resolution which we have sent to the Reference Committee. In our report we said that we are in favor of the principle of taking care of emergency medical and surgical non-service-connected disabilities of veterans in their community hospitals by their home physicians, and that we recommend that the State Medical Association declare itself willing to coöperate with the Legion in any such plan that may be adopted. We also stated in our report that we think that, as a medical society, we had better confine our advice to the medical aspects of the question, and leave the economic questions to other associations outside of medicine. I want to say that we are very much obliged to Dr. Wright, Dr. Meyerding and Dr. Johnson for their coöperation and advice, based on their knowledge of what has gone on in the American Medical Association.

In different counties, especially in Ramsey County and Hennepin County, the committees on veterans' legislation have been very active. Since we sent out a letter from our committee we have had replies from all over the state saying that they have passed the proposed resolutions regarding shifting the care of emergency cases to the home communities instead of sending those patients to veterans' hospitals. We have had different discussions with leaders of the Legion. Mr. Cliff, who is their national committeeman, and Mr. Sjoselius, chairman of the rehabilitation committee, say that they are willing to coöperate in so far as emergency cases are concerned. I think you know the rest of the arguments on the affair from your printing in MINNESOTA MEDICINE. I want to emphasize that the economic side of the problem is under discussion all over the county, and I think you have seen in the newspapers that opinions vary very widely. People in New York have come out against care of any non-service connected disabilities, and I think President Hoover recommended to Congress that they limit expenditures to service-connected disabilities. However, we have a large number of veterans' hospitals which cannot be scrapped without a good deal of loss. I think the subject is still open for discussion, and we should be willing to discuss the matter with the Legion in Minnesota to help find the fairest solution. I think we should limit our actual recommendations to advice on the medical aspects of the problem.

REPORT OF COMMITTEE ON STATE HEALTH RELATIONS

During the past six months two problems principally

have occupied the attention of the Committee on State Health Relations: the medical care of the poor, and the medical care of veterans.

MEDICAL CARE OF THE POOR

This problem has become more and more important since the onset of our present financial depression. Two years ago, in at least one county in this state, there was a working agreement between the doctors and the county commissioners. Early last year the subject was brought up through a case in Duluth, and a legal opinion was furnished the State Medical Association by Mr. Brist. We also had explained to us, the methods of contract used by various Iowa County Medical Societies. Later in the year further difficulties were presented, and in the January number of MINNESOTA MEDICINE we published extracts from the statutes and Minnesota Supreme Court rulings covering several vital points. At the Secretaries' Conference on January 23, 1932, we held a symposium on the subject, hearing the experiences of men from Iowa, Wisconsin, Illinois and Minnesota, including our own attorney general. The attorney general, Hon. Henry Benson, expressed his interest in our problem, and offered any assistance he may be able to give in settling any problems of law that may arise in regard to care of the poor. Within the last week a letter was referred to me which indicated that some confusion exists regarding parts of the problem. The Committee on State Health Relations is glad to help find the answers to any questions raised.

MEDICAL CARE OF VETERANS

This problem has had more and more attention from physicians during recent months. At present the ideas about it are so varied that it is hard to say what the outcome will be. We feel that the ordinary non-service-connected disabilities of veterans and especially acute and emergency disabilities should be cared for in their own communities by doctors of their own choice. Leaders in the American Legion in Minnesota feel that emergency disabilities of veterans should be treated in their home communities, but wish to see that much in successful operation before committing themselves further. Your committee has taken an active part in discussions of the medical aspects of the problem.

Your committee has declared itself in favor of the principle of the care of acute (emergency) medical and surgical non-service-connected disabilities of veterans in their community hospitals and by the home physicians of their own choice, and recommends that the Minnesota State Medical Association declare itself as willing to coöperate with the Legion in carrying out the details of such a plan.

No statement was made as to whether or not the medical care of non-service-connected disabilities of veterans should be at federal expense; it has been suggested that such a statement would hardly be within the sphere of a medical organization. However, it seemed to us that there should be no trouble in agreeing that at least all emergency non-service-connected disabilities would be more safely and more promptly treated in the veteran's home community than at a distant veterans' hospital. The whole problem of veterans' care is still under discussion and it seems to us that no further declaration is needed at this time.

T. H. SWEESTER, M.D.

Vice President Adams took the chair.

DR. COLLINS: The report of the Committee on State Health Relations was considered and the Reference Committee endorses the sentiment regarding the care of acute emergency medical and surgical non-service connected disabilities of veterans in their home communities.

The State Medical Association wishes to go on record as willing to coöperate with the Legion in carrying out the details of such a plan.

VICE PRESIDENT ADAMS: Dr. Wright, you were asked to discuss this report.

DR. C. B. WRIGHT: I didn't think there was anything to discuss about this report. I am thoroughly in sympathy with their action, and I would commend it to the House of Delegates for endorsement.

VICE PRESIDENT ADAMS: Is there anything further?

DR. W. A. COVENTRY (Duluth): I move the report be accepted.

DR. H. M. WORKMAN (Tracy): I second the motion.

The motion was put to a vote and carried.

VICE PRESIDENT ADAMS: Next is the report of the Heart Committee.

REPORT OF HEART COMMITTEE

It is with pleasure that I inform you of the fact that the organization of the Heart Committee is now complete and ready to function. We have, in the past year, increased our contacts by having fourteen men thoroughly qualified to speak on Cardiac Subjects approved by and added to the Extension Division of the University. The names of these men may be had on request.

We have also established contact with the Radio Committee and it is our plan to have a certain number of these hours on the Radio given over to discussions of cardiac subjects for the instruction of the lay public.

The success of the Heart Committee, however, depends upon the demands that are made upon it, and the greater the number of demands, the more good will the members of the State Society get from the Heart Committee.

We are now ready to supply qualified speakers that are willing and ready to go to any of the county societies' meetings to give talks on cardiac subjects as desired by these respective county societies.

During the last year, I am sorry to say that we had only one such request, which came from a group of men in the vicinity of Worthington and Fulda. At the request of Dr. Slater for Cardiac speakers, Dr. Fredrick Willius and Dr. Harry Oerting presented an evening's program which I understand was very excellent and well received.

It is the wish of the Heart Committee that many more such societies will request speakers. There is an excellent choice of men available, which should take care of the needs of any of the societies.

Where possible, it is the desire of the Heart Committee that the men located the nearest geographically to the county society requesting a speaker be used, especially in view of the fact that these men are all serving without recompense. For example, for a society located closer to Duluth than to the Twin Cities and with such excellent men available as we have in Duluth, the Heart Committee would suggest using these men rather than sending some from Rochester or the Twin Cities, and in the same way, in the southern part of the state, it would be better for us to send men from Rochester than from the northern part of the state. The Heart Committee would just appreciate this degree of coöperation.

May I assure you and also the various county societies that we can guarantee to put on a good show with the talent that we have available.

The following speakers are available for talks on heart subjects to medical societies and public health groups under the auspices of the heart committee:

Dr. H. E. Richardson, St. Paul	Dr. F. J. Hirschboeck, Duluth
Dr. E. T. Herrmann, St. Paul	Dr. E. L. Tuohy, Duluth
Dr. Harry Oerting, St. Paul	Dr. Olga Hanson, Minneapolis
Dr. C. N. Hensel, St. Paul	Dr. Reuben Johnson, Minneapolis
Dr. Max Hoffman, St. Paul	Dr. Morris Nathanson, Minneapolis
Dr. A. R. Barnes, Rochester	Dr. Moses Barron, Minneapolis
Dr. F. A. Willius, Rochester	Dr. Marx White, Minneapolis

Most cordially yours,

HAROLD E. RICHARDSON.

DR. H. E. RICHARDSON (St. Paul): You all have the report so I won't read it to you. Since this report went out, the committee has established contact with the Critchfield committee on Public Health Education. Now I feel our organization is complete. It functions through the central Heart Committee. Through Dr. Critchfield's committee, any requests for speakers for public health education, either of the profession or the lay public, will be handled through the Heart Committee.

Second, is the contact with the Radio Committee. The Heart Committee will sponsor talks to be given to the lay public over the radio on cardiac subjects.

Third, which I think is the most important, we have established contact through Dr. Thomas' committee by having a list of speakers on cardiac subjects approved by the Extension Division of the University, so that any requests for speakers on heart subjects coming into that division will be referred back and handled by the Heart Committee. So I feel now we have a central organization that should cover this subject throughout the state.

I feel we have a very excellent and representative group of men fairly distributed throughout the state.

I am now going to make request that the Minnesota State Medical Association send out a notice to the chairman of each program committee of the respective societies and ask that they devote one program in the year to cardiac subjects, for which we will be very glad to furnish the speakers. We ask that the request be made directly to the Heart Committee, and that they pick out from this list, which will be mailed to them, the men they choose with the subjects that they wish covered at that meeting. I think in this way we will get the coöperation of the various county societies and the facts and truths and latest things that have come up in cardiac work can be disseminated to the full society.

President Henderson resumed the chair.

DR. COLLINS: The Reference Committee in considering this report combined its recommendations with that of the latter part of the Hospitals and Medical Education Committee. The suggestion is made that in addition to the work of the Committee, a series of short courses be outlined at central points, such as the university, to be given two or three times a year for physicians who desire to avail themselves of this educational feature. The speakers might be selected in the same way as they have been in the past.

This is especially aimed at the Heart Committee report inasmuch as the work may be hampered by lack of material for demonstrations in outlying communities.

This suggestion was thrown in for the possibility of exciting some discussion on it.

DR. RICHARDSON: We had exactly that point in mind in establishing a relation with the university.

PRESIDENT HENDERSON: May I have a motion that the report be accepted?

DR. E. S. BOLEYN (Stillwater): I move it be accepted.

The motion was regularly seconded, was put to a vote and carried.

PRESIDENT HENDERSON: We will take up a few rather short reports here and hurry along. Report of the Editing and Publishing Committee.

REPORT OF THE EDITING AND PUBLISHING COMMITTEE

It is with regret that we have to report a deficit in the publication of MINNESOTA MEDICINE for the calendar year 1931, of $1,726.26.

This deficit occurred despite the fact that there was a shrinkage in cash income as compared to the year 1930, of only $568.67, and resulted principally because of the enlarged size of the journal and the greater number of illustrations used during the year. During 1931 there were printed 1,460 pages or an average of 121.6 pages per issue. This exceeds by 170 pages any previous volume. The number of pages printed during the year 1930 averaged 107.5 pages per month. This, compared with 1931, showed an increase per month of more than 14 pages an issue.

There were printed last year 1,092 pages of reading material and 368 advertising pages. The reading pages included 138 scientific papers and 24 case reports. Had all this material been supplied to the members of the Association in book form, it would have made a volume of 1,460 pages, with 318 halftone illustrations. There was an average of 26.5 halftone illustrations for each monthly issue during the year.

Effective January 1 the Editing and Publishing Committee decided to standardize on a 100-page journal monthly. Other economies have also been effected. If this standard of 100 pages is adhered to throughout the year, which it undoubtedly will be, it is almost certain that the publication of the journal for 1932 will show a surplus. For the first quarter of the present year our report shows a net suplus of $494.70. The May number contains the largest volume of local advertising that any issue of the journal has ever carried, and plans are under way by which it is hoped to materially increase local volume of display advertising for the year. Obviously this depends to some extent upon general business conditions but, regardless of the very unfavorable conditions in all lines of business, we feel safe in promising that there will be no deficit for the present year.

All kinds of publications have experienced tremendous losses in advertising volume during the past two years, and no relief of any consequence is anticipated for 1932. This volume loss is chargeable mainly to national business, all of which is handled through the Coöperative Medical Advertising Bureau, an auxiliary of the American Medical Association. MINNESOTA MEDICINE volume for 1932, in this class of advertising, compares more than favorably with other state journals. This is due in no small degree to the high standing and fine reputation which the journal has throughout the country. But, as before stated, the Editing and Publishing Committee has reduced the size of the journal for 1932 and effected other economies which should be sufficient to more than provide for the anticipated loss of volume and leave a surplus for the year.

At the close of the year our records show that subscriptions were paid on 2,063 members, and that the journal was still being mailed to 135 delinquent members. There were upon our list 103 doctors paying the annual subscription of $3.00, who are not members of the State Association. There are being mailed out monthly 359 copies on the complimentary list, to exchanges, to advertisers, etc., leaving a surplus each month of approximately 140 copies. A large number of these surplus copies is used in supplying miscarried copies, as samples to advertising prospects, and to prospective non-member subscribers.

While the past two years have shown a deficit in the publication of MINNESOTA MEDICINE, it is only fair to call attention to the fact that each of the eleven preceding years shows a very satisfactory surplus over publication costs, since it was established fourteen years ago, and that the total receipts over the entire period, from all sources, substantially exceed publication costs.

Statement showing income and expense for the year is attached.

Very truly yours,

J. R. BRUCE, *Business Manager.*

STATEMENT OF CASH RECEIPTS AND DISBURSEMENTS, MINNESOTA STATE MEDICAL ASSOCIATION, PUBLISHERS MINNESOTA MEDICINE

For Period January 1, 1931, through December 31, 1931

SOURCE OF CASH RECEIPTS

Display advertising		$ 9,966.84
Illustrations		84.11
Member subscriptions		4,126.00
Non-member subscriptions		308.59
Bad accounts recovered		64.86
Gross cash receipts		$14,550.40
Less:		
Discount and commission		
Advertising	$1,331.57	
Subscriptions	13.23	
Collection fee	16.66	
	$1,361.46	
Total net cash receipts		$13,188.94

CASH DISBURSEMENTS

Journal expense	$14,915.20
Cash deficit for period	$ 1,726.26
Accounts receivable Jan. 1, 1931	$1,024.13
Accounts receivable Jan. 1, 1932	$1,226.32

DR. J. M. ARMSTRONG (St. Paul): The report of the Editing and Publishing Committee was sent you some time ago, and you all have a copy of it.

We are sorry to say we had a deficit last year, and we hope we will have no deficit this year. In fact, we are ahead of the game at the present time, which will leave the disposition of this report to the Reference Committee.

DR. COLLINS: I believe the Reference Committee had no recommendation excepting to recommend the acceptance of their report.

DR. H. M. WORKMAN (Tracy): I second the motion

The motion was put to a vote and carried.

PRESIDENT HENDERSON: Report of the Radio Committee. Is Dr. Maxeiner here?

REPORT OF THE RADIO COMMITTEE

During the past year Dr. O'Brien has continued to make his weekly talks over WCCO. He has covered a great assortment of medical subjects interesting to the public, in a manner that has cast much credit upon our State Association. The fact that his talks are timely and on subjects about which the people wish information is evidenced by the fact that he is receiving a large number of letters regarding his broadcasting, many questions are asked and requests for talks and explanations, either by mail or radio broadcasts, are made. As a result of his radio efforts, Dr. O'Brien has given more than fifty talks before lay organizations such as parent and teacher associations, women's clubs, etc., with audiences ranging from 60 to 1,200. He has also addressed numerous scientific meetings throughout the state, hospital staffs, surgical societies and a large number of nurses' association meetings. In this way, Dr. O'Brien has been spreading in a very active manner medical education. The direct contacts, Dr. O'Brien feels, are due directly or indirectly to his radio broadcasting.

During the past few months our Committee has considered the advisability of extending our broadcasts to other radio stations such as KSTP, the University, etc. We feel that undoubtedly we could obtain the cooperation of the University Medical Department who would handle their own broadcasts. KSTP at one time offered us the use of their station but have not had the funds to finance another speaker such as Dr. O'Brien nor do we know of a speaker who is not in some way in competition in private practice who would meet all of the peculiar demands of the rest of the medical profession. It is essential that such a speaker be not enagged in competitive medicine. No action has finally been taken upon this matter.

WRHM broadcasts over 1250 kilocycles which happens to be the same as that assigned by the National Radio Commission to the University of Minnesota, Carlton College and St. Olaf's College. Recently WRHM has requested the Radio Commission for full use of this wave length which means that the University, Carlton College and St. Olaf's College would be entirely displaced from the air. Because of the character of the broadcasts from WRHM, this is of particular importance to the medical profession as they repeatedly advertise free medical examinations at Rosedale Hospital which is owned and operated by Troy Miller who, it is also reported, owns WRHM. I have communicated with the other members of my committee and have sent copies of their replies to the Secretary of the State Society. Every one of this committee not only opposes the extension of WRHM but are entirely in favor of curtailing the hours of WRHM and giving additional time to the educational institutions. At my suggestion, editorials have appeared in both MINNESOTA MEDICINE and the Journal Lancet. The matter of the request of WRHM is apparently coming before the National Broadcasting Association at an early date which, we understand, is the last hearing before that committee.

Respectfully submitted,
C. N. HENSEL, M.D.
C. B. LEWIS, M.D.
J. J. MCGROARITY, M.D.
L. H. RUTLEDGE, M.D.
GEORGE STEVEN, M.D.
F. P. STRATHERN, M.D.
A. L. VADHEIM, M.D.
S. R. MAXEINER, M.D., *Chairman.*

DR. COLLINS: The Reference Committee want to commend the part that WCCO has taken in regard to educating the public. The Reference Committee goes on record urging all possible influence on the National Radio Commission in an effort to curtail the time allowed station WRHM. They suggested that the Radio Committee assist Dr. Price in any possible way.

You are all familiar with the dissemination of health matters that Brinkley broadcasts, and also what trouble the station at Muscatine gave the medical association in Iowa with regard to the tuberculin testing of cattle. We think it is the duty of every delegate and every doctor in this state to influence the Radio Commission to curtail the time of these stations that disseminate knowledge to the public the way WRHM is doing at the present time.

PRESIDENT HENDERSON: You have all heard the report.

DR. COLLINS: I move the adoption of the report.

The motion was regularly seconded, was put to a vote and carried.

PRESIDENT HENDERSON: We will now jump a little further down the list to the report of the Committee on Medical Economics. Dr. Pearce is ill, I am sorry to say, and cannot be here, but Dr. Braasch has Dr. Pearce's report. Dr. Braasch will present the matter, and Dean Scammon will talk afterwards.

DR. W. F. BRAASCH (Rochester): I am sorry to have to give this report, which is entirely the work of Dr. N. O. Pearce. I happen to be one of the members of the committee, but the work is entirely that of Dr. Pearce and he has put a tremendous lot of time and endeavor into it, and the excellence of his report, I am sure, you will subscribe to. I am awfully sorry he was unable to be present here, today, on account of ill health.

Dr. Braasch read the report of the Committee on Medical Economics.

REPORT OF THE ECONOMICS COMMITTEE

This committee, authorized by the house of delegates last year, has spent a very considerable amount of time during the past year, but have limited their studies to the question of number and distribution of physicians in Minnesota, with special reference to what the future may hold in this direction.

You will recall, at a meeting a year ago, it was clearly demonstrated that there are a great many more physicians in the United States per capita than any other country in the world and that Minnesota had only 882 people per physician and seemingly a definite increase, each year, in the number of physicians, altogether out of proportion to the increase in population.

The committee has endeavored to determine, as nearly as possible, just what the present situation in Minnesota is and what we may expect in the future under present conditions and what we may be able to do to change the present unhealthy trend.

Before we had pursued our investigation very far, we concluded that we should treat this matter as a Minnesota problem and deal with it directly as a Minnesota problem as any effort directed to a country-wide recognition for adjustment of the situation, would necessarily, be very slow in producing any favorable results.

Before presenting the lantern slides we wish to take the opportunity to express our very great appreciation of the coöperation of Dean Scanlon of the Medical School and other departments of the University and the State Board of Medical Examiners in the assembling of this material.

We also wish to express our appreciation to the 135 physicians who so kindly and promptly replied to the questionnaires sent out to the physicians in the ten key counties of Minnesota.

(SLIDE NO. 1)—This slide represents the result of the study of the population and distribution of physicians, worked from the details of township reports by the United States census for 1930. As you will note in the legend all areas in the state having more than 500 people to the township, that is 36 square miles, are represented by the cross stripe. From 300 to 500 people to the township by the horizontal bar, and from 100 to 300 by the perpendicular bar, and all areas with less than 100 people to 36 square miles are left blank.

The geographical position of the doctors in the state are represented by the dots, the large dots meaning more than one physician and the small dots meaning only one physician. You will also note those areas in the northern part of the state in which we find that there are no physicians within 15 miles area, but at a glance one can see that there is no area in the state of Minnesota in which there is a population that could possibly support a physician in which there is not adequate medical service available.

(SLIDE NO. 2)—This slide presents a study similar to that in Slide No. 1, except that the distribution of physicians is here shown in relationship to assessed property valuation. The areas in cross bars have over one million dollars to the township. In horizontal bars, five hundred thousand and to one million to the township. In perpendicular bars, two hundred thousand to five hundred thousand to the township, and territory with less than two hundred thousand assessed valuation per 36 square miles is left in blank.

This study shows very clearly and convincingly that there are physicians in every part of the state which has either population or wealth enough to furnish a reasonable income and that there are a great many physicians located in areas of such small valuation that it is remarkable that they are able to exist at all.

From the foregoing two slides, one is justified in drawing conclusions that rural Minnesota is well supplied with physicians wherever the population or the wealth of the territory would indicate that it is possible for a physician to subsist.

(SLIDE NO. 3)—This slide presents a slightly different phase of the study. Ten of Minnesota's best southern counties were selected as typical of the best of Minnesota rural districts. In this territory there was a fairly even distribution of physicians, a fairly even distribution of wealth and a fairly even distribution of population. The counties containing the stars are the ones used in this study. Many factors were taken into consideration, such as population, number of physicians, retails sales, etc. In all, there were six variables involved in arriving at the index. Now, if these counties have the correct number of physicians for population, wealth, etc., then those areas in which there is no barring of any description also have about the right number of physicians.

Those areas which have a diagonal bar have too many physicians and those having a horizontal bar might have room for a few more physicians.

It is remarkable how close this index applies to most of the states; however, every one of the 135 physicians who answered the questionnaire stated that there were only enough physicians in this territory to adequately care for the population and 85 of the 135 stated that there are now more physicians in these counties than is necessary to give adequate medical care to the people.

It certainly gave us much food for thought to find what a large percentage of these physicians had a net income of less than two thousand dollars per year.

There are a number of considerations which have to be gone into when one contemplates any plan for the future physician population in the states. We must first consider the source of our increase in physicians and we must consider possible increase in population in the state and consider the possible increase in the death rate of physicians now in the state. In considering the increasing number of physicians we have to consider not only the men who are graduating from our own State University Medical School, but the possibility of an influx of physicians from other medical schools. It would do no good to decrease the number of graduates from our school unless we could, in some way, develop barriers which would keep out unnecessary numbers from other medical schools.

(SLIDE NO. 4)—This slide shows the definite line of increase in the number of medical graduates for the United States. It shows that the number of graduates is rapidly increasing over the number of physician deaths.

(SLIDE NO. 5)—This slide shows the number of graduates from Minnesota in five-year periods from 1885 until now. You will note the definite increase since 1913 or 1914.

(SLIDE NO. 6)—This slide shows the steady increase in the number of physicians in Minnesota since 1906—an average increase of 46 physicians per year. It is interesting to note, at this point, that regardless of the number of graduates from our University Medical School that the number of physicians has increased at about the same rate, showing that physicians from outside come in to make up for any shortage in the medical school class.

(SLIDE NO. 7)—This slide shows that there are about one-third of all of the students that graduate from Minnesota who leave the state for other fields.

(SLIDE NO. 8)—This slide shows the population curve of the state and would indicate that we will, within a very short time, reach our maximum population.

(SLIDE NO. 9)—This shows curve of rural population of Minnesota and would indicate that there is no expectancy of material increase in rural population.

(SLIDE NO. 10)—This shows the relation of Minnesota to the general increase of populations of the United States and certain foreign countries during the past ten years.

(SLIDE NO. 11)—This slide shows the graphic illustration of the increasing rate of physicians over population during the last fifty years.

(SLIDE NO. 12)—This indicates the increasing number of Minnesota graduates locating in Minnesota.

(SLIDE NO. 13)—This slide presents a study of the age incidents of physicians in Minnesota showing that a large majority of the physicians in Minnesota still have a good many years of practice before them. It will be noted that in 1914 the average age was 42.8 years, while 17 years later the average age is only 46.6 years. It is clear, from this study, that we have no great need of increasing the number of physicians in the state because of an expectancy of a higher death rate.

(SLIDE NO. 14)—It might be interesting, at this point, to note that the number of physicians in the states immediately west of Minnesota are greatly decreasing in number.

(SLIDE NO. 15)—A glance at this slide would indicate that the incidents of acute disease, which occupies a large part of the time of the average physician, is greatly on the decrease.

We believe that conclusive evidence has been presented, in this study, to show that there is immediate need for the medical profession of the state to take such steps as are possible and practical to reduce the annual number of incoming physicians to a point where there will be at least no further increase in the aggregate number of physicians in the state until such time as an increase in population will make it possible for such physicians to make adequate incomes.

To this end we recommend that the matters in this study be referred to the appropriate committees of the State Association, that the University Relationship Committee confer with the authorities of the University Medical School and the proper committee confer with the Boards of Licensure and such other steps be taken as seem advisable to bring about this end.

This committee also has spent some time in a study of compulsory health insurance on which Dr. Michel has a brief summary.

We believe the committee should be continued for at least one more year as there are many other subjects on Medical Economics which should be thoroughly studied.

Respectfully Submitted
WILLIAM BRAASCH.
JOSEPH MICHEL.
N. O. PEARCE, *Chairman.*

PRESIDENT HENDERSON: Dean Scammon, will you discuss this report?

DEAN SCAMMON: I think Dr. Pearce ought to be complimented on the amount of work he has put into this study. It is true we have contributed some of the more unintelligible charts to it. And these charts make me feel, as a statistician, that I am justified in quoting another statistician, who very carefully figured out that if all statisticians were laid out cold, end to end—it would be a good thing.

What I think Dr. Pearce's report brings out most strikingly is the thing that we are running into as a general situation in this country: the decrease in rate of growth of population and the concurrent increase in the rate of people trained for special services. It is hard for us to realize how great the decrease in growth of population has been. Although the United States did increase in population about sixteen per cent in the last ten years, it grew very much like an omelet that puffed up at its two ends. Fifty per cent of the increase in population in the United States, in the last ten years, took place in two states. In the north central district, of which we are a part, the growth in population was a good deal like the present growth in France. It was a very slow growth. In other words, we have got past the pioneer stage.

In this state we grew at the rate of 7.5 per cent in the last ten years, which is a higher rate than that of most of the north central states. But we also are facing a slowing down of population. The S-shaped curve illustrates that. This is characteristic of not only the population in Minnesota, but characteristic of almost any place inhabited by the European races that you study. There have been about two hundred of these regions studied and, so far as I know, only a few of them have fallen down from this course. One of them was the home of our distinguished visitor who has left, who remarked that almost anything might happen in Minnesota, and to whom I would reply, that even the impossible can happen in Chicago.

Along with this decrease in rate of population, which started thirty years ago, in 1890, not to decrease, we have had this very large increase in men who are entering the profession of medicine.

In the country, as a whole, the number of medical students is growing over five times as fast as the population. In this state, the number of licensed physicians is increasing at present at about two and one-half times, relatively, as fast as the population. In other words, for about every four hundred new people who come into this state by birth or migration there is one physician added to the group. This is the situation you have to face. It is one which is very specific and undeniable.

This condition has been recognized in other professions, but other professions, it seems to me, do not have the acute situation that the medical profession does. After all an engineer can turn to industry, a lawyer can turn to insurance or to real estate (as he generally does), but a physician tends to remain a physician. He has been trained for that purpose and he is going to continue a physician in the great majority of instances.

Some of my friends have argued with me on this subject, claiming that the increase in the number of physicians is a good thing; for it brings about competition. They forget that all of our history indicates that increased competition in medicine beyond a certain point does not work well. You can go back into history and prove quite easily that when there was too large a number of practitioners there was neither fair remuneration for the physician nor good service for the population. Also, we must remember that when we graduate a student we recognize perfectly well that we are just starting him on his profession, that he ought to be getting better for twenty years hence, and that an increase in financial competition will not bring this about.

I have outlined to you a little of the Minnesota situation. There can be no question about it. You can check it in any fashion you wish, but you will find an enormous increase of men who are entering into practice. It does not seem to depend directly on the number of men we graduate from the Medical School, for as one of these charts shows, about one-third of our graduates leave the state, and they have left in this proportion for forty years—in hard times and in good times. It does not seem to me that, perhaps, we have a mode for control in this state that is not present in other states. Through its Medical Society, its Medical Boards. and its School working together, Minnesota was the first state to gradually get standards to the benefit of the profession and the people. These agencies moved together step by step. As they increased the requirements in the School, they increased the re-

quirements for entrance into the state. So then we have the advantage of the Medical Society. We have had the advantage of effective examining boards, including a basic science board. And I assure you that you have a medical school that is willing to coöperate with you in any way possible in considering the nature of this rather serious problem that Dr. Pearce has brought forward.

PRESIDENT HENDERSON: Dr. Collins.

DR. COLLINS: I have nothing on that report.

DR. C. B. WRIGHT: Mr. President, Mr. Brist has an important announcement to make.

MR. BRIST: I have just talked to Judge Seely over in Minneapolis, and he told me he filed an order dismissing the case and sustaining the action of the Basic Science Board in denying a certificate to this fellow Shenk who is head of the naturopathic society.

PRESIDENT HENDERSON: Is there any further discussion? What shall we do with the report?

DR. F. A. WILLIUS (Rochester): I move the report be adopted.

The motion was regularly seconded, was put to a vote and carried.

PRESIDENT HENDERSON: Next is the report of the Historical Committee, Dr. Hamilton.

DR. A. S. HAMILTON (Minneapolis): You probably recall that the Committee on Necrology has been fused with the Committee on History of Medicine, so it becomes my duty to, more or less, give a double heading. I will make it as brief as I can.

Dr. Hansen has fulfilled the office of necrologist of our society for a number of years, and she prepared what I shall present today.

Death has called a number of our fellow workers. Many of these have been referred to already in the columns of MINNESOTA MEDICINE, the Journal of the Association, and we, therefore, desire only to express sorrow at the departure of these men.

The necrologist's report is headed May 4, 1931, through May 23, 1932, and refers only to members of the Minnesota State Medical Association.

Dr. Hamilton read the report of the necrologist.

NECROLOGIST'S REPORT

May 4, 1931, through May 23, 1932

MEMBERS OF MINNESOTA STATE MEDICAL ASSOCIATION

J. W. Andrews, Mankato. Born 1849. Rush Medical College, 1877; Bellevue Hospital Medical College, 1880. Aged 83.

John Bensom Brimhall, St. Paul. Born 1862. University of Pensylvania, 1890. Died December 21, 1931. Aged 69.

Gustav Fischer, Minneapolis. Born 1860. Washington and Jefferson Medical School, Philadelphia, 1896. Died June 28, 1931. Ager 71.

Albert E. Flagstad, Minneapolis. Born 1891. University of Minnesota, 1921. Died January 26, 1932. Aged 40.

J. A. Freeborn, Fergus Falls. Born 1864. Rush Medical College, 1889. Died January 25, 1932. Aged 67.

L. A. Fritsche, New Ulm. Born 1862. University of Michigan, 1887. Died June 18, 1931. Aged 69.

John Farquahar Fulton, St. Paul. Born 1856. University of Pennsylvania, 1877. Died January 31, 1932. Ager 76.

Thorvald Holen, Minneapolis. Born 1874. Minneapolis College of Physicians and Surgeons, 1902. Died January 12, 1932. Aged 58.

Walter J. Kremer, Minneapolis. Born 1878. University of Minnesota, 1911. Died April 2, 1932. Aged 53.

Walter Waugh Murphy, Minneapolis. Born 1885. Northwestern University, 1911. Died June 1, 1931. Aged 45.

Daniel D. Murray, Duluth. Born 1859. Albany Medical College, 1881. Died November 6, 1931. Aged 72.

Henry O'Brien, St. Paul. Born 1862. University of Pennsylvania, 1888. Died September 16, 1931. Aged 69.

Jon Vincent O'Connor, St. Paul. Born 1867. University of Minnesota, 1895. Died April 5, 1932. Aged 65.

John Jackson O'Hara, Janesville. Born 1868. University at Kingston, Ontario, 1898. Died July 6, 1931. Aged 63.

Reuben Nathaniel Palmer, Lanesboro. Born 1893. University of Minnesota, 1926. Died November 3, 1931. Aged 38.

Soren P. Rees, Minneapolis. Born 1870. University of Minnesota, 1897. Died October 2, 1931. Aged 61.

Walter Henry Robilliard, Faribault. Born 1861. General Medical College, Chicago, 1884. Died November 1, 1931. Aged 70.

John D. Simpson, Minneapolis. Born 1858. Northwestern University, 1882. Died October 18, 1931. Aged 73.

Henry Longstreet Taylor, St. Paul. Born 1857. University of Cincinnati, 1882. Died January 2, 1932. Aged 74.

William Jesse Taylor, Pipestone. Born 1844. Rush Medical College. Died April 15, 1932. Aged 88.

Frederick Goodwin Watson, Worthington. Born 1871. Hamline University, 1903. Died January 11, 1932. Aged 60.

Henry L. Williams, Minneapolis. Born 1869. University of Pennsylvania, 1892. Died June 14, 1931. Aged 62.

PHYSICIANS NON-MEMBERS OF STATE ASSOCIATION AT THE TIME OF DEATH

Frederick Barret, Gilbert. Born 1875. Rush Medical College, 1897. Died November 4, 1931. Aged 56.

Silas E. Brown, St. Paul. Born 1856. N. Y. University Medical School, 1883. Died October 10, 1931. Aged 75.

Dudley C. Frise, Minneapolis. Born 1887. N. W. University, 1904. Died January 10, 1932. Aged 45.

Robert H. Harrison, St. Paul. Born 1862. Died December 13, 1931. Aged 69.

Eugene Hubbell, St. Paul. Born 1855. Hahnemann Medical College, Chicago, 1883. Died April 20, 1932. Aged 77.

James F. Kline, Anoka. Born 1862. University of Minnesota College Hom. Medicine and Surgery, 1893. Aged 70.

Albert Kumpf, Hot Springs, S. D. Born 1901. University of Minnesota, 1928. Died October 12, 1931. Aged 30.

Joseph J. McKinnon, Wadena. Born 1863. University of Minnesota, 1893. Died July 31, 1931. Aged 68.

Frederick J. Mitchell, St. Paul. Born 1879. Northwestern Medical School, 1909. Died October 8, 1931. Aged 52.

Lincoln E. Penny, St. Paul. Born 1860. Rush Medical College, 1885. Died March 28, 1932. Aged 72.

Frank Lee Puffer, Bird Island. Born 1853. New York Medical College, 1877. Died May, 1931. Aged 78.

H. J. Rowe, Minneapolis. Born 1848. Died November 20, 1931. Aged 83.

Stephen O. Watkins, Bloomington. Born 1851. N. Y. Medical College, 1880. Died April 11, 1932. Aged 81.

Hugh Spaulding Willson, LaJolla, California. Born 1877. University of Minnesota, 1904. Died 1931. Aged 55.

DR. HAMILTON: Our second addition refers strictly to historical matters.

Dr. Hamilton read the report of the Historical Committee.

REPORT OF THE HISTORICAL COMMITTEE

Your Historical Committee desires to report as follows for May, 1932. The Committee has been in operation since 1927 and has each year reported its method of procedure and its progress and we are as-

suming it is unnecessary to again go over these matters.

At the present time, we have collected a large amount of manuscript, a considerable portion of which is ready for publication. We now plan to include in our first volume a history of the State Medical Association and a history of certain other very early medical organizations, including those along the Minnesota River Valley, the Mississippi River Valley, the St. Croix Valley and Duluth. This will include the following counties: Winona County, Wabasha County, Olmsted County, Goodhue County, Dakota County, Ramsey County, Hennepin County, Washington and Chisago Counties to include Stillwater, Marine, Taylors Falls and St. Croix Falls; the north shore group to include St. Louis, Lake and Cook Counties; Stearns County; the Minnesota River Valley group to include Scott County, Carver County, Nicollet County, Brown County and Blue Earth County; Steele County, including Owatonna, and Freeborn County including Albert Lea. To this will be added a manuscript prepared by Dr. Fairchild, dealing with the conditions under which the pioneer physician operated.

Our greatest difficulty to date has consisted in the inequality of the preparations made by different organizations and naturally we cannot well neglect the record of one area which chronologically belongs with another area, perhaps ready for publication. Up to date, Dr. Workman has had charge of the specially heavy work of the county medical societies and has collected a large amount of material which varies all the way from the most meager statement of facts or nothing at all concerning certain counties to records which are reasonably complete and even in typewritten form. Dr. Klaveness' history of Wright County is already in print.

We feel that we have availed ourselves of about everything that is possible from those members of the society who are old enough to have a firsthand recollection of interesting occurrences, but there still remains considerable to be done in the way of a search for names and dates and lists of officials, and about the only way that these can be gotten is through a search of the early newspapers which are on file in the State Historical Society, but it is hardly to be expected that members of the society from distant points should come to St. Paul for this search.

Throughout its work, the Committee has avoided as far as possible paying out the Association's money and such money as has been expended has been almost wholly for typing of manuscript and for photostats, but we feel that the time has arrived when someone must be employed to conduct a search in the library of the State Historical Society for the purpose referred to. Up to date, in only one instance has any money been allotted to pay for search for original data. In that instance, seventy-five dollars was allowed in 1929 for an exhaustive search into medical legislation in Minnesota. Through some of the graduate students at the department of history of the University or from other sources, we can have this work in the Minnesota State Historical Society library done at very reasonable rates and we ask that the Society authorize us to undertake this expenditure.

So far as is possible, we shall have the history of each county or district medical society prepared directly by or under the auspices of the official representative of that society. Where no one can be found to prepare the necessary material, the Committee will act on its own responsibility.

Our expenditures for 1930 were $43.98, for 1931 were $43.50 and for the past twelve months have been $137.40. We ask that the State Medical Association appropriate $150.00 in addition to our unexpended balance for last year of $362.60.

Respectfully submitted,
A. S. HAMILTON, *Chairman.*

DR. COLLINS: There is nothing in the report of the Reference Committee that has not been brought up by Dr. Hamilton in his report.

In recommending the report of the Historical Committee, we especially commend the large volume of work accomplished by this committee, and recommend the increase of their appropriation as requested in their report if it is found to be necessary.

We recommend that the delegates take the matter of coöperation with this committee up before their local societies with the recommendation that they aid in every way possible. We recommend that a committee be appointed in each local society to obtain the information desired, subject to the endorsement of the Historical Committee.

PRESIDENT HENDERSON: You have heard the recommendation, gentlemen.

DR. F. A. WILLIUS (Rochester): I move it be adopted.

The motion was regularly seconded, was put to a vote and carried.

PRESIDENT HENDERSON: The next report is that of the Committee on Hospitals and Medical Education, Dr. Gilbert J. Thomas.

The report was presented.

DR. COLLINS: The report of the Committee on Hospitals and Medical Education outlines the courses held in Mankato, Winona, Hibbing, Olivia, Fulda, Fergus Falls, and Marshall. In reviewing this report the Reference Committee feels that considerable work has been done. The feeling in reading the report is that interest seems to be lagging in this phase of the work. The suggestion is made that in addition to the work of the committee, a series of short courses be outlined at central points, such as the university, to be given two or three times a year for physicians who desire to avail themselves of this educational feature. The speakers might be selected in the same way as they have been in the past.

I repeated there what we had in regard to the Heart Committee report.

PRESIDENT HENDERSON: You have heard the report, gentlemen.

DR. F. A. WILLIUS (Rochester): I move its adoption.

The motion was regularly seconded, was put to a vote and carried.

PRESIDENT HENDERSON: Report of the Committee on Public Policy and Legislation.

DR. H. M. JOHNSON (Dawson): Mr. President and Members of the House: We haven't so much to report on yet, but we have some things that are starting, and we have already done something.

At the last meeting of the secretaries it developed and was thoroughly brought out that the Shoulders' resolution would not be acceptable to the people of the medical profession of Minnesota.

As time went on and reactions came in, it was found as far as Minnesota was concerned, that something had to be arranged to see what could be done to substitute for that resolution. Accordingly, since there were other matters of importance, it was thought wise that I should go down to Washington with the legislative committee of the American Medical Association.

The passing of resolutions and letting them go to sleep hasn't occurred in this state for a number of years. It has worked out that when something is passed, something has happened.

One time we thought that by passing resolutions in the House of Delegates, wanting such-and-such a law,

that would give us the law. We found, very sadly, through experience that we had to go about it in a practical way in order to get what we wanted. When we learned to do things in a practical way, we got results.

I went along down to Washington and helped out the best I could, but I want to tell you right now that if some of the members of this committee hadn't known something about legislation they would not have gotten anywhere. At one time it looked as though it was the intention to put a wet blanket on the whole meeting.

While there it also developed that the Minnesota plan—as Dr. Fishbein said, you can't tell what will happen in Minnesota—was the one that seemed acceptable to the veterans. It is a wonderful piece of work the committee has done. It means millions and millions of dollars. In one way, they are through, as the building of hospitals which were contemplated to provide 128,000 more hospital beds has been stopped and the greatest advance in state medicine that has ever been attempted by any nation any place in the world has been stopped. Therefore, the results already obtained and the contacts made are so important they are hard to realize. The committee could not continue to push the Shoulders' resolution further as no other of the groups would consider it. They did organize a liaison committee which will continue to work and study the proper method of caring for veterans. Another thing that was essential was to get in touch with our Congressmen. We had contact with them. We had them all together one night, and we put this proposition that had been worked out before them. They were heartily in accord with it. I told them they had let tariff legislation and veterans' legislation go entirely too far and it was high time to sit down quietly and think it over and see what they could do to retrieve some of the harm they had already done. They agreed fully. They thought that the plan the A. M. A. and Legion is working out together was all right. That wasn't all. The veterans' administration promised the American Hospital Association the right to investigate the cost per day for a veteran in their hospitals. This is important. There isn't that coöperative spirit you think there is on the part of the veterans' administration.

In regard to the state campaign: I don't care to what party you belong, or who you are interested in, but work for somebdy and make us of your rights as a citizen. Nobody respects a man who sits on a fence and is afraid of his shadow. You have a right to be for anybody you want to be for, but be for them and don't be dead.

There is a man I make no apologies for speaking a good word for, and that is Oscar Swenson, who is a candidate for the railroad and warehouse commission. He was the leader in our bills on the statute of limitations in the basic science fight, and has been with us 100 per cent all the time. I hope you will remember not only to vote for him, but to work for him because he is entitled to it. He is an outstanding man, a man with outstanding ability and well qualified for that position, which is one of the most important positions in the state. Therefore, I hope you will not take the opportunity to return the good and kind acts he has done for us by doing something for him.

PRESIDENT HENDERSON: We will have to speed along if we are going to get through today. We will now hear the report of the Committee of Medico-Legal Affairs. Is Dr. Hengstler here? (Absent.) Dr. Collins, can you make a few remarks on that?

REPORT OF COMMITTEE ON MEDICO-LEGAL AFFAIRS

The Committee on Medico-Legal Affairs has held no definite meetings during the past year, except that the Chairman of this Committee has been present at the meetings of the officers and Committee Chairmen, which have been held at the call of the President.

One matter of reference, only, has been submitted to this Committee, during the past year, which was correspondence from the American Medical Association relative to the formation of a Criminologic Institute in the state of Minnesota. This file was given due consideration by the Committee, and it was unanimously voted by the Committee to recommend it favorably to the Council of the State Association, and the Secretary was so informed by letter under date of September 21, 1931.

There is one matter which the Committee desires at this time to present, for consideration, to the House of Delegates. It is believed advisable that the present law, permitting the Superintendents of State Hospitals for the Insane to discharge criminally insane individuals at their own discretion, be changed. This recently received some publicity when a murderer was discharged by one of our State Hospital Superintendents, after having been committed as criminally insane by District Court, causing considerable comment by members of the Judiciary in this state. The undersigned Chairman of the Committee on Medico-Legal Affairs has been in conference with Judge Hugo Hanft, senior judge in Ramsey County, regarding this situation. Judge Hanft has expressed himself as believing that the law should be changed so as to place the matter of discharge of such patients from State Institutions in the hands of the committing Court, instead of in the Hospital Superintendent. He believes that the Court should be empowered to appoint a commission of phychiatrists to examine the patient and ascertain the advisability for his discharge, this Commission reporting directly to the Court itself. The Association of Judges in the state of Minnesota is to give this matter consideration at their annual meeting in July, 1932, and it is highly probable that necessary steps will be initiated to attempt a change in this law at the next session of the Legislature. It is the feeling and belief of the undersigned Chairman of the Committee on Medico-Legal Affairs that the Minnesota State Medical Association should go on record as recommending this change in the law, and that a copy of this proceeding be sent to Judge Hanft, Senior Jurist in Ramsey County, for him to present at the meeting of Judges in July. It has not been possible for the Chairman of the Committee on Medico-Legal Affairs to take this matter up officially with his Committee, due to the fact that the Committee is widely scattered, and it is rather a difficult matter to handle through the mail. The Chairman, however, believes that he may speak for his Committee, in requesting the House of Delegates to recommend this change in law, and present, officially, their recommendation to the Senior Jurist in Ramsey County, Judge Hanft.

No other specific matters have come to this Committee during the past year. Further study is being made of the medical expert testimony in the State, with an idea of securing, ultimately, some constructive legislation, as mentioned in two previous annual reports of this Committee. This matter has also been discussed with Judge Hanft, who concurs heartily in the opinion of the Committee that such legislation would be desirable.

Respectfully submitted,
W. H. HENGSTLER, *Chairman.*

DR. COLLINS: I think I had better read part of the report because some of our comments may need some background.

"One matter of reference, only, has been submitted to this committee during the past year, which was cor-

respondence from the American Medical Association relative to the formation of a Criminologic Institute in the state of Minnesota. This file was given due consideration by the committee, and it was unanimously voted by the committee to recommend it favorably to the Council of the State Association, and the Secretary was so informed by letter under date of September 21, 1931."

Then you have all the rest of this report in printed form.

The next paragraph refers to the matter of discharging insane patients from insane institutions at the sole instigation of the superintendent, and the recommendation for the correction thereof.

The Reference Committee makes the following comments: "The report of the Committee on Medico-Legal Affairs was considered, and the suggestion concerning a Criminologic Institute for the state of Minnesota was discussed. This committee is at a loss to know just what a Criminologic Institute is, and feels that the Committee on Medico-Legal Affairs should explain to the House of Delegates the function of this institution. Further, it would be a great education to the House of Delegates if the committee would give us some idea of what mechanism we have in the state of Minnesota for the prevention and detection of crime.

"The recommendation in regard to the discharge of the insane patient from state hospitals is commendable.

"The recommendation of the Committee on Medico-Legal Affairs is concurred in regarding the employment of a commission of psychiatrists to examine the patient and ascertain his ability to be discharged, said commission reporting directly to the court itself, or to other proper authorities."

PRESIDENT HENDERSON: You have heard the report, gentlemen.

DR. F. A. WILLIUS (Rochester): I move its adoption.

The motion was regularly seconded, was put to a vote and carried.

PRESIDENT HENDERSON: Report of the Committee on Schools for Laboratory Technicians.

REPORT OF THE COMMITTEE ON SCHOOLS FOR LABORATORY TECHNICIANS

The Committee on Schools for Laboratory Technicians has had presented to it a number of problems concerning the present situation of commercial and non-commercial schools and of the attitude of the members of the medical profession toward these schools and toward the technicians. Certain bad practices exist and in an attempt to correct these, the following steps are recommended.

Your committee has approved the enclosed three resolutions which have been prepared by Dr. Kano Ikeda. The committee urges the House of Delegates to pass these resolutions and thus enable it to give the recognition of the State Medical Association to those Schools of Laboratory and X-ray Technicians which fulfill the requirements as stated in the resolutions.

Your committee has formulated a plan for the dissemination of information to the members of the Minnesota State Medical Association with regard to technicians. This embodies the publication of a number of articles by Dr. Charles R. Drake in MINNESOTA MEDICINE, which would discuss (1) the necessity for discouraging prospective students of laboratory and X-ray technic because of the overcrowding of this field; (2) the importance of hiring only those technicians who are graduates of recognized and non-commercial schools of laboratory and X-ray technic; (3) the vital importance of referring laboratory and X-ray work only to ethical laboratories supervised by competent medical directors or to ethical physicians who are specialists in these fields; (4) the discouragement of the practice of many physicians who require their technicians to make diagnosis and to give treatments.

Your committee is convinced that the passage of these resolutions and the publication of these articles will do much to improve the present situation in the field of laboratory and X-ray technic. It will also permit the committee to answer authoritatively the numerous letters which are being received from prospective students of laboratory technic.

LEO G. RIGLER, M.D., *Chairman.*

RESOLUTIONS

Whereas, A school or a course of training for medical technicians (both clinical laboratory and X-ray technicians) may be defined as an institution established or maintained for the purpose of instructing men and women to become technical workers in a clinical pathological or radiological laboratory, by offering courses of studies, together with necessary hours of laboratory practice which are essential in the proper training of such workers; under the direction of a qualified medical man, preferably a clinical pathologist or a radiologist, with the aid of qualified instructors and with teaching material sufficient to carry out the program of proper instruction and operated under the code of ethics which governs the conduct of all reputable medical institutions;

Whereas, The present day commercial schools for medical technicians, without exception, do not meet the above definition in all of its essentials;

Whereas, There are incidents to indicate that a large number of ill-informed or ignorant young women are being solicited to enroll in these schools, by misrepresentation through agents, letters or advertisements, and as a result hundreds of improperly trained technicians are being turned out of these schools annually;

Whereas, It is highly doubtful if these commercial schools for technicians will ever succeed as educational institutions, therefore

RESOLVED, that the Minnesota State Medical Association condemns the practices and policies of these schools and withholds any approval of them until such time as they shall come within the definition herein stated.

BE IT FURTHER RESOLVED, That this body herein records its disapproval of the identification of any member of the Minnesota State Medical Association with such a commercial school in any capacity which may give aid to the school in any manner whatsoever, as detrimental to the maintenance of high ethical standard of the medical profession.

KANO IKEDA, M.D.

Whereas, There is a distinct demand for well trained medical technicians, and, as a result, an increasing number of young women are seeking properly conducted training in Medical Technology, and whereas the courses in Medical Technology offered at the University of Minnesota are found inadequate to accommodate but a small portion of these applicants,

RESOLVED, That the Committee on Schools for Laboratory Technicians of the Minnesota State Medical Association recognizes the clinical laboratories (including the X-ray department) of a general hospital of not less than 100 beds, under the direction of a qualified medical director, which meets the minimum requirements for recognition by the American Society of Clinical Pathologists (and the Radiological Society of North America) as the proper and logical place to train and instruct, a limited number at a time, of future medical technicians.

KANO IKEDA, M.D.

Whereas, The American Society of Clinical Pathologists has endeavored, through registration and approval, to recognize the schools and the courses of training for medical technicians conducted by recognized hospital laboratories under a qualified medical director and,

Whereas, There are schools and hospital laboratories in the State of Minnesota which have the approval of the said Society through registration or recognition,

RESOLVED, That the Committee on Schools for Laboratory Technicians of the Minnesota State Medical Society proposes, for the present, at least, to recognize only those institutions which enjoy the approval of the American Society of Clinical Pathologists through registration or recognition and withhold its recognition from all others, pending such registration and approval.

KANO IKEDA, M.D.

Whereas, Both the Radiological Society of North America and the American Society of Clinical Pathologists, through their respective subsidiary agencies, namely, the American Registry of Radiological Technicians and the Board of Registry of Technicians, are endeavoring to raise and maintain the minimum standards of educational and technical qualifications of technicians in their respective fields, through certification and registration, and

Whereas, The American Medical Association, the American College of Surgeons, the American Hospital Association and other responsible national medical organizations have given their unqualified support to this program of certification and registration by the aforementioned Societies, therefore.

RESOLVED, That the Minnesota State Medical Association, through its Committee on Schools for Laboratory Technicians, extends its hearty coöperation to these Societies in their efforts to elevate the standards of qualifications of medical technicians by recommending to its constituent members and County and District Societies that they urge the clinical laboratory and X-ray technicians under their influence, to identify themselves with the national registry through registration.

KANO IKEDA, M.D.

DR. C. R. DRAKE (Minneapolis): I feel this is rather an important report from several standpoints. Dr. Rigler, Dr. O'Brien, Dr. Schulze, and others have been working rather strenuously the past year along this line.

As you know, there are a number of commercial schools for technicians in Minneapolis and St. Paul. We have been especially pleased with these. In fact, throughout the United States we are pleased with them, and through very high class advertising, not the kind spoken of a little while ago, a great many people have been inveigled into taking these courses.

I feel it is the duty and the privilege of the medical profession to take this question of medical technology in their own hands and govern it, rule it, and control it, and not leave it to lay people or to indiscriminate men, medical men who are not even members of our Association.

It was with that in mind that we asked you to approve our resolution that we have passed. I think it is very important to give the committee a status in handling the situation.

During the past year I have been on the stand a couple of days in prosecuting one of these institutions, and at the present time there is still litigation from another concern in Minneapolis along this line. We have to carry ourselves very guardedly and carefully not to get into trouble, but we need your support and we need the support of the state association as well as the Ramsey County and the Hennepin County Societies. It is also advisable that the physicians throughout the state know a little more about medical technicians and where they stand. The country is taking on a new class that will run up into thousands of people who should not be doing the work they are doing, perhaps, but whose work should be done, largely, by medical men. These people are taking over some of the remunerative work some of the medical people ought to be doing. We are getting too many especially along this line. There is room for trained medical technicians, and a good place for them, and they are a great help to us.

We all have this report, but I simply call your attention to one or two things the committee has done. The committee has given you these resolutions which we hope you will pass. This committee urges the House of Delegates to pass these and thus enable it to give recognition to other state medical societies, to those schools of laboratory and X-ray technicians which will fulfill the requirements as stated in the resolution, governed by the American Society of Clinical Pathologists. The American Society of Clinical Pathologists and the Radiological Society of North America are working quite harmoniously with the American Medical Association. I feel that the Minnesota State Medical Association ought to do the same and help your committee to do something constructive along this line.

They have formulated this program to get out a series of articles to discuss the necessity of discouraging prospective students. There are too many in the field already. The importance of hiring only those technicians who are graduates of recognized and non-commercial schools of laboratory and X-ray technic; the vital importance of referring laboratory and X-ray work only to ethical laboratories supervised by competent medical directors or to ethical physicians who are specialists in these fields; the discouragement of the practice of many physicians who require their technicians to make diagnosis and to give treatments.

Your committee is convinced that the passage of these resolutions and the publication of these articles will do much to improve the present situation in the field of laboratory and X-ray technic. It will also permit the committee to answer authoritatively the numerous letters which are being received from prospective students of laboratory technic.

I have probably received and answered, during the past year, 300 of these letters which have come from people who have been fooled into this proposition by undesirable advertising.

DR. COLLINS: The Reference Committee went over all this report and read all the different resolutions, and they felt there was so much technical language concerned with these resolutions and so much possibility of getting into legal entanglements, or treading on somebody's toes, that the matter was referred to the Council. This was taken up with the Council last night and discussed by them informally, and the Council will act further on it.

PRESIDENT HENDERSON: You have heard the report, gentlemen.

DR. E. S. BOLEYN (Stillwater): I move it be adopted.

The motion was regularly seconded, was put to a vote and carried.

PRESIDENT HENDERSON: Report of the Committee on Public Health Nursing.

DR. COLLINS: I believe our recommendation was that the report be referred to the Council for action.

PRESIDENT HENDERSON: Your recommendation is adopted.

DR. COLLINS: The Committee on Public Health

Nursing is having a meeting today, and asked for the privilege of reporting at tomorrow's session.

PRESIDENT HENDERSON: Report of Committee on Industrial Practice.

REPORT OF THE COMMITTEE ON INDUSTRIAL PRACTICE

Soon after the appointment of your Committee on Industrial Practice, the State Industrial Commission was notified of the purposes of our Committee by your secretary, Dr. Meyerding, and by the Committee Chairman. Very gracious replies were received. Many of the communications with the Industrial Commission have been in writing for permanent record and are on file with your secretary and the Chairman of the Committee. Also, copies of all correspondence between members of our Association, insurance companies, and representatives of the Industrial Commission have been filed for reference.

The Committee has carefully considered the individual problems brought to its attention. It realized quite soon that it could have no official or legal standing with the Industrial Commission. It has attempted

(1) To function as a voluntary liaison body between the insurance companies and members of the medical profession.

(2) To ascertain the type of problems which require our consideration, as a guide to future policy, and

(3) To accumulate some experience and make specific recommendation to the State Association regarding solution of the problems involved.

No instances have arisen where it has seemed necessary or advisable for the Committee to function in the matter of adjustment of charges for services rendered by a physician. In one case an insurance company, The Hartford Insurance Company (Sexton, Mordaunt & Kennedy, Attorneys) expressed its willingness to submit the question of reasonableness of charges made by Dr. Rudie of Mazeppa to the Committee for arbitration. The matter is still unsettled by the attorneys representing both parties and we were privately advised not to mix up in the controversy until the Industrial Commission had considered the contentions of both parties, regarding the charge for medical services. This is the only important case of its kind which has come up. We may still have opportunity to be of service in case the Industrial Commission will submit the matter to us for arbitration.

The question whether or not an insurance company may dictate limitations or methods to be employed by a doctor in treatment of an injury is not as serious as it might seem. We would refer to the memorandum from Dr. G. S. Wattam of Warren who enclosed a letter from the United States Fidelity and Guaranty Company. This letter was in no wise unreasonable, and simply specified use of ward beds and limitations and consultation advice before diathermy, baking, massage, and light treatment could be used, in order to reduce expense. It also specified ether anesthesia as a factor for safety. Dr. Wattam stated, "We feel that an injured patient coming to our office should be treated in such a manner as we deem best suited to the individual case." Upon submitting the matter to the Commission we were informed that the Commission agreed with Dr. Wattam. Nevertheless, the insurance company would have the privilege of changing medical attendants if any practitioner resorted to "padding" the treatment and rendering larger bills for what the company might regard as superfluous therapeutic measures. As all of us know, this is exactly what has occasionally happened. The insurance companies have reluctantly paid some large bills for special forms of therapy, but are careful to request advance approval of treatment the value or necessity of which may be questionable; or they have appointed doctors who do not routinely use such treatment.

Most of the correspondence in our files has to do with the right of the *employer* (usually the Insurance Company) to name the medical attendant of an injured employe. The Industrial Commission is definitely on record, committed to the opinion that the employer may nominate the medical attendant for his injured employe. In this opinion the Commission is supported by the State's Attorney General (see correspondence in files). To change this opinion or ruling of the Commission the State Medical Association would necessarily undertake either

(1) To appeal the decision as suggested in a letter from Mr. Williams of the Commission "in order that the matter may be definitely and finally decided,"

(2) To introduce a bill before the legislature changing the statute so that the employe could choose his own surgeon,

(3) To seek to secure appointment of men upon the Industrial Commission who would interpret the law in a manner favorable to the wishes of a majority of the State Medical Association.

In the report of the Chairman for this Committee before the midwinter session of the Council

(a) The first suggestion was an appeal from the decision of the Commission, the State Association to make an appropriation for legal advice and action. (Our present opinion regarding the advisability of such procedure is now modified.)

(b) Securing changes in the personnel of the Commission involves the State Association in a continuation of political or quasi-political activity which a certain element of the State Association seeks to avoid.

(c) Introduction of a new bill before the next legislature to change the statute should depend upon the wishes of a majority of the members of the State Association.

The following quotation from Page 43 of the considerations of the committee perhaps expresses the present situation:

> "However, there is some question as to the wisdom of securing any change in existing conditions so far as it concerns the ruling of the Industrial Commission regarding the right of Insurance Companies to name the surgeon for attendance of injured cases. From such information as has been available it would seem that Insurance Companies have every inclination to be conciliatory rather than arbitrary in the matter of adjustment of payment for medical service. The Industrial Commission has not been small in its attitude upon the subject and is inclined to be liberal to a reasonable degree in the matter of allowances for medical and hospital bills. With a changing personnel this may not always be the case. On the other hand, if the present system is changed, the State Association may be faced with a "Standard Fee Bill" such as is employed by the Industrial Commission in neighboring states; another step toward *State Medicine*. As stated in my midyear report to Dr. Workman and the Council, 'It is perfectly natural that some men put a higher value on their service than other men place upon their own service. Also it is obvious that one hernia operation, care of a fracture, removal of a cataract, or attendance upon an injury may involve very variable exactions in time spent, responsibility, and even in results, according to the individual circumstance. All of us know this so well that we can understand how difficult it is to try to get a common fee basis to cover conditions in injuries or operations in different individuals which have exactly the same name.' It is doubtful whether we would be as well off with a Standard Fee Bill as we are under present arrangements. and the Insurance Companies seem satisfied as things are now."

If any change in the statute is secured by legislation it might result in the employe's resorting to treatment by osteopaths, chiropractors, Christian Scientists, and other cults, a privilege he does not at present enjoy. Neither the medical profession nor the insurance companies are interested in a change which would permit such a contingency. It might lead to a very complicated situation resulting in

overthrow of the entire system of compensation insurance, even to the institution of a new form of State Employment Insurance, with its possible political evils, and a socialistic involvement of our profession, leading toward "State Medicine." We believe this would be an economic calamity.

Your Committee therefore recommends

First, that the Committee on Industrial Practice of the State Medical Association be continued with reappointment of some of its present personnel.

Second, that the said Committee continue its study of the problems involved, accumulation of data and the practices and experiences of other similar medical bodies in other states.

Third, that no change in the statutes be attempted until more information is accumulated and submitted to the Council.

Fourth, that further friendly effort be made to induce the Industrial Commission by mutual understanding and coöperation to encourage a liberal attitude regarding choice of attending physicians for injured employes and compensation for medical service; to utilize the Committee on Industrial Practice in controversies in which the medical profession is involved.

Respectfully submitted,
FRANK E. BURCH, St. Paul, *Chairman.*
ARTHUR N. COLLINS, Duluth.
ALEX. R. COLVIN, St. Paul.
GEORGE DUNN, Minneapolis.
J. P. MCDOWELL, St. Cloud.
J. C. MICHAEL, Minneapolis.

DR. COLLINS: Dr. Burch has gone. There was considerable to get us into some discussion on this report.

The Reference Committee makes these observations with regard to the report of the Committee on Industrial Practice:

"The question of fee schedules should be thoroughly discussed, and it is imperative in the face of present conditions for the organization to protect itself by attempting to get together on some agreement.

"The present financial situation demands that a careful study of the problem of fees and fee schedules be undertaken.

"Inasmuch as there seems to be considerable confusion in the minds of this group in regard to the question of fees, and as to the ethics of industrial practice, we recommend that either this committee or some committee appointed for the purpose, undertake a study of the whole question of fees as applied to industrial cases, and report at our next meeting on the advisability of a minimum fee schedule as applied to this work."

This matter was taken up before the Council last evening. They discussed it, and voted to refer the matter of an investigation of fees to this committee for further action.

PRESIDENT HENDERSON: This is an important committee, and I think they have done very good work, indeed. I think you get the gist of what has been said, and that is that this further problem of fees is referred back to this committee rather than to create a new committee. Heretofore the feeling of that committee has been that it was not within the field of their activities to talk much about fees or consider fees, but they acted more as a protective body between the industrial commission, insurance companies, and the practitioner. As I understand it now, Dr. Collins, this committee goes further afield and looks into the question of fees.

DR. COLLINS: As I understand it, Mr. President, in this discussion that was had in the Reference Committee and also the discussion that occurred in the Council meeting last evening, a sort of canvass as to fees prevailing in the different districts throughout the state is desired.

It doesn't take very much for us to see that a man who operates on a traumatic hernia, if it is unquestionably traumatic hernia, out in some small town, will say, "Here is unquestionably a hernia, and I can do this," and he goes ahead and fixes it up and gets a nice fat fee, maybe charging $200. The insurance company argues that it is too high, that they can get all the hernias operated they wish, in the city, for $50, $75, $100, or what not. It is a jumbled up mess in every respect. I am just merely taking hernias as an illustration. It is the same with compound fractures, infected and non-infected.

The tendency of the insurance company is, apparently, to beat the doctor down. There are so many fee schedules being passed around through the profession for signatures that this whole thing is a matter for investigation for this committee. That is the reason the Council so voted.

DR. F. H. MAGNEY (Duluth): The insurance companies are always after us for fee schedules, which are dangerous things. A fee schedule for fracture of a leg might be a very nice thing in simple cases, or something that is very simple to take care of. But if you give a minimum fee schedule for fracture of the leg, and if you get a complicated one requiring a lot of time and service, they hold you to the minimum fee schedule. I think we should go very cautiously in outlining a minimum fee for the simple reason that they will hold us to that, and it is very difficult to get away from.

PRESIDENT HENDERSON: I have had conversation with Dr. Burch a number of times, and I think it is the responsibility of the committee to avoid any schedule of fees, if possible, and that is the effort.

DR. C. B. WRIGHT (Minneapolis): I would like to ask why societies could not organize and establish a minimum on certain well standardized procedures as hernia.

DR. ADAMS: What results are they accomplishing where they have organized?

DR. C. B. WRIGHT (Minneapolis): I cannot answer that question but feel that it should be studied.

PRESIDENT HENDERSON: I know this is an important subject, and I think all of you have the gist of the thing, that it is recommended this committee try, by a gentlemen's agreement or some other arrangement, to establish, if possible, a tariff of fees that will be, more or less, reasonable.

It was regularly moved, seconded, and carried, to accept the report of the Committee on Industrial Practice.

PRESIDENT HENDERSON: Report of the Committee on Military Affairs.

Dr. F. L. Smith read the report of the Committee on Military Affairs.

REPORT OF COMMITTEE ON MILITARY AFFAIRS

At the special meeting held January 23, 1932, the Committee on Military Affairs recommended the following program to be presented to the Association for adoption.

(1) That all practicing physicians in the state of Minnesota, eligible to become members of the Medical Reserve Corps, should be canvassed through the County Societies.

(2) That a letter setting forth the importance of all eligible physicians to join the Reserve, be placed in the hands of Presidents of the County Societies.

(3) That all members of the Association and especially World War Medical veterans should use every opportunity to assist the State Association

Committee, which is endeavoring to educate all War Veteran Associations in the matter of care and hospitalization. This is of utmost importance to every community in which there is a local hospital.

(4) That the Presidents of the County Societies be forwarded a copy of the inclosed letter.

Regretting that the services of Major W. L. Hoffman, attached to the 88th Division, as medical instructor for the past six years, have been discontinued, the Committeen on Military Affairs recommends that the State Association request the Surgeon General, through military channels, that replacement be made as soon as conditions warrant.

Respectfully submitted,

LT. COL. F. L. SMITH, *Chairman.*
MAJOR MARTIN AUNE.
MAJOR L. J. HOLMBERG.
MAJOR W. L. EKLUND.
LIEUT. B. B. SOUSTER.
LT. COL. W. G. WORKMAN.

DR. SMITH: Of course, we all know that a big cut is being made in the War Department, and that the amounts allocated to the Corps Areas are small, so that there is a reduced personnel in the Army and especially on the detached officers' leave. As Major Hoffman, who filled the office so well in the 88th Division, has been discontinued, we are recommending that when the time comes he be replaced, so that it will be a matter of record.

As to what the Reserve can do, we think, in times of peace, there is nothing here of any importance. Nevertheless, it is something. You will notice in the schedule shown by Dr. Braasch that the average physician in Minnesota is about forty-three years old. That was in 1914, and in 1931 it was about forty-six. That means that a great majority of the practicing physicians in the rural districts are coming in in the army age, up to thirty-five years of age as a maximum. Those are the men we have to get into the Reserve in order to keep the skeleton structure going.

Then the contacts of medical men who have been in service is very important regarding the Legion proposition. The average man in the country districts doesn't know what is going on. When some chap comes along representing the Legion and is trying to combat our program, if we had a medical man right in the community belonging to the Legion, he could help our program immensely.

DR. COLLINS: No report.

DR. J. M. HAYES (Minneapolis): I move the adoption of this report.

The motion was regularly seconded, was put to a vote and carried.

PRESIDENT HENDERSON: Report of the Committee on Cancer.

DR. H. E. ROBERTSON (Rochester): It isn't very fitting that the end hairs on the tail of the dog should wag the dog very long, especially at this hour.

REPORT OF COMMITTEE ON CANCER

Your Committee on Cancer was appointed by the president of the Association on March 8, 1932, and six days later, on March 14, your very active secretary asked that this committee make a report of the activities of the committee. Manifestly he is over-optimistic about the resources for activity and energy usually displayed by any committee for any purpose. Nevertheless, it would seem to be a fitting occasion to rediscuss some of the problems which have faced the medical profession and in the attempted solution of which your association has proved themselves to be actively interested.

At first thought, such activities as the State Association may properly sponsor would seem to be laid out along well worn and even hackneyed lines. As a minimum, whenever the subject of cancer is brought up, members of the medical profession meeting in august assemblies call attention to the deplorable increase of cancer morbidity and mortality, point with pride to the efforts of the profession to reduce this, and abjure each and every one to broadcast the fact that cancer should be treated early.

As a maximum, it is customary for some particularly enthusiastic representative of this group to arrange for public meetings at which the people are informed of the medical profession's enthusiasm for the curability of cancer and the extreme desirability of consulting the home physician on the occasion of lumps, hemorrhages, unhealed sores and indigestion.

But the questions facing us have become considerably more complex. Experts in the diagnosis and treatment of cancer tell us that the education of the laity has been carried on well apace with the times, perhaps even too vigorously, with the result that in many people a wholesome respect for the significance of some symptom or sign has been converted into a paralyzing fear of cancer which is quite capable of effecting more harm than would result from an actual carcinoma. Moreover, these experts hint in no unguarded terms that the foremost object of any educational campaign against cancer should be the family physician, whose indifference or lack of knowledge is frequently the cause for fatal delay in diagnosis and proper treatment. Therefore, they advise that we slow up the attack on the ignorance of the laity and transfer activities from patient to physician and that all along the line, beginning with the student of medicine, an intensive program of education be launched, emphasizing the proper diagnosis, prognosis and treatment of malignant growths.

But even these measures are inadequate. Supposing our patient, sufficiently educated, presents himself early enough and the doctor, sufficiently wide awake and well informed, recognizes the necessity for early intervention in a case of malignant tumor, what is the next step? How much does he know about what ought to be done in an individual case and if there are limitations in his knowledge or ability in this line, to whom should or could he turn for authoritative information, advice or assistance? In short, what are the resources in this state, for the proper diagnosis and treatment of obscure malignant conditions? But even if we are all well acquainted with these resources, what about the economic side? This patient is our patient and if we, ourselves, may feel unprepared to handle his condition to the best advantage, are we going to lose him entirely, because of transfer to those who appear to be specialists in treating this particular field? Furthermore, how can be allayed the suspicion that the major foundation for the whole program of cancer education lies in the desire for personal aggrandizement of those who either possibly or really deserve to be regarded as experts in the cancer field?

Your Committee has no panacea for the solution of these perplexing questions, but its recommendations may constitute a renewed effort toward some progress. We recommend, first, that you give your approval to the invitation already issued by the Council of the Minnesota State Medical Association to the American Society for the Control of Cancer to bring about a cancer survey of the state through their state chairman, Dr. Wm. A. O'Brien, and representatives of the national association, and further that every possible coöperation and effort be offered by the members of this Association toward facilitating the completion of such a survey. The Committee understands that this survey will analyze, with considerable exactitude, the resources afforded in this state for the care of malignant disease.

Second, that the State Medical Association, by appropriate resolution, recommend to the Dean of the Medical School that the medical faculty be urged to thoroughly review in their various courses before the students the subject of the diagnosis and treatment of malignant disease.

Third, that each county and district medical society be urged to devote at least one meeting a year to the discussion of malignant diseases in all their various phases.

Fourth, this committee be empowered to bring about at least once a year, a public meeting in every city and village of the state, at which the subject of malignant disease may be discussed by suitable members of the profession.

JOHN ROTHROCK, M.D.
J. C. LITZENBERG, M.D.
ARTHUR COLLINS, M.D.
H. E. ROBERTSON, M.D., *Chairman.*

This committee has a report. It would have been a longer report and a good deal more blistering speech, but it is too late. The committee is too young, and the Society is not ready for it.

Next year, if the committee is in existence in its present composition, it will have a report that we hope will be advanced on the program and have a chance for consideration.

You are all sick and tired of hearing about cancer. You all know what cancer is, and you all know how to treat it. The trouble is, we don't know what cancer is and don't know how to treat it. We are facing a serious situation in regard to cancer, as we are to other things, because cancer is understood and being judged by the laity in a way which is sometimes superior and paramount to the understanding and judgment of the medical profession. Some time or other we are going to have the laity force upon us the way in which cancer people should be taken care of. Unless we lead, we are going to have to follow.

There is going to be a survey in this state made by a cancer commission appointed from the American Society for the Control of Cancer, on the invitation of the Council of this Association. When that report comes in next year we will have some comments to make upon it, I hope.

PRESIDENT HENDERSON: Dr. Collins.

DR. COLLINS: In view of what Dr. Robertson has just said, I don't know whether this review of our committee actually applies, but I am going to read it to you.

"The report of the Committee on Cancer suggests the prevailing inadequacy of diagnosis in cancer cases, and states that there is no panacea for the multitude of perplexing questions in this respect. The committee recommends that cancer survey throughout the state be brought about through the state chairman, Dr. W. A. O'Brien, and representatives of the National Association for the Control of Cancer, and that every possible coöperation be offered by the members of the Association. This committee will undertake this survey during the summer.

"Second, that the State Association recommend to the Dean of the Medical School that review of the courses before students on the diagnosis and treatment of malignant disease be stressed. Third, that each county and district medical society be urged to devote one meeting a year to the discussion of cancer. Fourth, that the Committee on Cancer be empowered to bring about at least once a year a public meeting in every city and village for the discussion of cancer.

"We recommend that we delete from the report, the following:

'Moreover, these experts hint in no unguarded terms that the foremost objective of any educational campaign against cancer should be the family physician, whose indifference or lack of knowledge is frequently the cause for a fatal delay in diagnosis and proper treatment. Therefore, they advise that we slow up the attack on the ignorance of the laity and transfer activities from patient to physician, and that all along the line, beginning with the student of medicine, an intensive program of education be launched emphasizing the proper diagnosis, prognosis, and treatment of malignant growths.'

"It is our opinion that the first and second recommendations should be accepted, but we believe the third and fourth are impractical."

PRESIDENT HENDERSON: You have heard the report.

DR. ADAMS: I move it be accepted.

The motion was regularly seconded, was put to a vote and carried.

PRESIDENT HENDERSON: Amendments must be presented. Amendments to the by-laws can be voted on at the next meeting, but amendments to the constitution must be read at this meeting and then held over for one year.

DR. COLLINS: "Article IV, Section 4: Affiliate members should be those members of component districts or county medical societies, who upon their own request, and having held membership for a period of twenty-five years in this Association, and having reached the age of seventy years, or who through physical disability are unable to engage in active practice, and who shall have been declared affiliate members of their own district or county medical society at its regular meeting, such action having been approved by the Council.

"Article V: House of Delegates: The House of Delegates shall be the legislative and business body of the Association and shall consist of (1) Delegates elected by the component county and district societies, (2) Councilors, (3) The President, (4) The President-Elect, (5) Ex-officio Secretary and Treasurer, (6) Past Presidents who shall be entitled to the privileges of the floor but without the right to vote.

"Article VI: Council—The Council shall consist of the Councillors, the President, the President-elect, the immediate Past President, and ex-officio the Secretary and the Treasurer. Besides its duties mentioned in the by-laws, it shall constitute the Finance Committee of the House of Delegates. A majority of Councilors shall constitute a quorum."

PRESIDENT HENDERSON: Is there any old business, or any new business?

Secretary Meyerding made some announcements.

SECRETARY MEYERDING: We have a communication from Dr. Chesley in regard to the White House Conference. Do you want to take it up now?

DR. F. J. SAVAGE (St. Paul): I make a motion that this matter be referred to the Council at any future meeting of the Council.

The motion was regularly seconded, was put to a vote and carried.

PRESIDENT HENDERSON: Motion to adjourn is in order.

SECRETARY MEYERDING: We will meet tomorrow noon at twelve o'clock in the Minnesota Club.

On motion regularly made and seconded, it was voted to adjourn at one-thirty o'clock.

Editor's Note: The committee reports, although not read at the meeting of the House of Delegates, appear in full, with the exception of the report of the Committee on Hospitals and Medical Education, which consists of a list of the short courses presented in various towns in the state and is omitted for the sake of brevity.

(Report of the second meeting of the House of Delegates will appear in the October issue.)